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**‘THERAPEUTIC ENCOUNTERS’ AT A MUSLIM SHRINE IN
PAKISTAN: AN ETHNOGRAPHIC STUDY OF
UNDERSTANDINGS AND EXPLANATIONS OF ILL HEALTH
AND HELP-SEEKING AMONG ATTENDEES**

A thesis submitted to Middlesex University in partial fulfilment
to the requirement for the degree of
Doctor of Philosophy

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ABSTRACT

In Muslim countries, shrines of Sufi saints serve as sources of healing. Why people decide to seek healing at shrines and their experience whilst there remains largely un-researched. The aims of this study were to: investigate the explanatory models of sickness among attendees at a Muslim shrine particularly in relation to this choice of help-seeking; explore individuals' perceptions and experiences regarding the role of the shrine; and propose a theory explaining the meaning of attendees' problems, their choice of healing resource and the role it played.

An ethnographic approach was used to allow exploration of the topic from the perspectives of those seeking help at the Shrine. Semi-structured interview, incorporating the Explanatory Model (EM) of sickness (Kleinman, 1980), and participant observation were used to collect data over a period of three months.

This study was conducted at a Muslim shrine in Pakistan. Twenty six attendees participated, including those seeking healing, carers, and a Shrine caretaker. The results highlighted magic and possession as the main explanations of the problem that brought them to the Shrine. Participants' experiences of everyday oppression, and adverse social factors, such as poverty, poor quality of medical care, and domestic violence seemed to play a significant role in the development of their problem.

The Shrine served as a therapeutic landscape, the prevailing social conditions, built environment and perceptions of attendees combined to produce a place 'conducive to healing' (Gesler, 1992), that allowed healing to take place. Possession acted as a vehicle for a subtle change in the family dynamics in which family members appeared complicit. The movement and changes in power, the positive reframing of symptoms/problems and the renegotiation of identity essentially transformed the individual and made the experience therapeutic.

The results generate a unique set of knowledge in regard to the role of shrines in Pakistan as culturally sanctioned places allowing therapeutic change and healing.

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I wish also to thank my mother for her support and interest in my studies and my family in three different continents for encouraging me throughout this period; and my family in this country for dinner table discussions that gave me new ideas and food for thought. Last but not least I am indebted to Judith for her immense support, both emotional and intellectual, throughout this process and for her endurance and continuing inspiration during the times when I struggled to go on.

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CHAPTER 1: INTRODUCTION

This thesis describes a qualitative ethnographic study exploring the explanatory models of people attending a Muslim shrine in Pakistan in search of healing for mental distress. This chapter describes the aims of the study, the rationale behind conducting the study, the theoretical framework which has been used to address the research questions and explanation of some terms commonly used throughout this dissertation.

AIMS OF THE STUDY

The area I have chosen to explore in this study concerns help-seeking for problems of mental distress at a Muslim shrine in Pakistan. From the review of the literature, it is clear that the nature of problems that people frequently take to shrines are ones that are commonly labelled as mental disorder by health professionals (Malik and Bokharey, 2001 ; Raguram et al., 2002 ; Padmavati et al., 2005). However, this labelling represents the views or perspectives of health professionals, and not necessarily those of the people actually engaged in the help-seeking process. This research aims to shed light on questions such as how sickness or mental distress is perceived and described by an individual or their families in Pakistan, and how their explanations relate to their decision to seek help at a religious shrine. It also aims to illuminate the role a shrine plays in changing the problem or the appraisal of the problem by an individual or a family; and what treatment or help a shrine offers to mentally distressed attendees that may effect either a reappraisal or a resolution of the problem with which they present.

The aims of the study are to:

- Investigate the explanatory models of sickness among attendees at the Shrine particularly in relation to their reasons for visiting the Shrine and choosing this particular method of help;

- Explore individuals' perceptions and experiences regarding the role a Muslim shrine plays in alleviating or curing the perceived sickness and mental distress; and
- Propose a theory explaining the meaning of attendees' problems, their choice of the Shrine for healing purposes and the role this Shrine plays in addressing their physical, emotional, social, cultural and spiritual needs and effecting therapeutic change.

It is hoped that the theory proposed will identify the factors that influence the development and maintenance of individual's explanatory models and how these lead to the choice of the Shrine as a source of help. The theory will also address and propose an explanation for the complex processes taking place at the Shrine and the effects of these on attendees. In addition, the knowledge generated through this study should assist health professionals in Muslim and multicultural societies, to become more culturally competent when caring for and treating clients from diverse backgrounds. It will also enable health services, whether in Pakistan or in other Muslim settings, to become more able to embrace popular healing traditions and make attempts to integrate popular understandings and explanations into the practice and delivery of health care services.

KLEINMAN'S EXPLANATORY MODEL (EM)

Kleinman's explanatory model (EM) has been used in this study to elicit explanations of help-seeking among participants. According to Kleinman, explanatory models are "the notions about an episode of sickness and its treatment that is employed by all those engaged in the clinical process" (Kleinman, 1980, p. 105). EMs may be elicited through the use of narratives that people construct to make sense of an illness within the context of their culture. They are based on the beliefs and values of the individual and are often manifested in their behavioural responses to the illness. The individual's and their family's EMs tell us how they make sense of any given episode of illness

and how they will evaluate the treatment provided and all possible alternative treatments. The EM of the practitioner informs us how a sickness is understood and the treatment plan developed. The interaction between the EM's of a patient, their family and the practitioner takes a central position in the delivery of health care. They offer "explanations of sickness and treatment to guide choices among available therapies and therapists and to cast personal and social meaning on the experience of sickness" (Kleinman, 1980 p. 105). Further discussion and exploration of Kleinman's EM and how it informed the study methods will take place in later chapters.

RATIONALE AND BACKGROUND FOR THE CURRENT STUDY

Choosing this topic for my PhD research was heavily influenced by my previous experience of working in the field of mental health in Pakistan. Regardless of cultural background, research shows that many people use religion as a coping mechanism to deal with mental distress (Koenig et al., 2001 ; Paragament et al., 2004). Moreover, ill health and misfortune may be understood in religious or spiritual terms (Kleinman and Good, 1985). In Pakistan and other non-western societies, where many aspects of life are organised around religious beliefs and activities, religion may become very important when ill health is encountered. Seeking help from faith healers and going to religious venues for a variety of health issues is common practice. "The need is for dependence upon someone or something, limits or rules, which can be known and counted upon" (Fleischman, 1989 p. 21) and this can be comforting and soothing in the times of crisis and perceived loss of control.

I have always found the whole social phenomenon of seeking healing for what is commonly labelled a 'mental disorder' at a shrine intriguing. My professional training was strongly influenced by western bio-medical models of distress and illness. While training, it was essential for me to evaluate behaviour in the light of Western classification systems (DSM or ICD). However, whilst working as mental health nurse, I witnessed large numbers of people seeking healing at

shrines. Although I have always perceived religion and religious activity in a positive light, the sufferer's isolation from their family and society as a whole, spending weeks, months, or even years in a shrine in the absence of any certainty of healing is behaviour which raised many questions. I therefore embarked upon this project in order to gain a deeper understanding of insiders' perspectives of this social phenomenon.

Thousands of people in Muslim societies visit shrines in search of help and healing in times of need. These needs may include a search for better health outcomes, fulfilment of wishes concerning wealth, and success, or the elimination of perceived threats from others. The way an individual perceives his or her health is directly related to their worldview. Culture, educational level, values and belief systems, family and social structure, the availability and accessibility of health care and many other factors may impact upon this perception. People from Pakistan strongly believe in and often seek comfort and healing through religion and religious rituals. Great importance is therefore placed on using religious healing and healers to address ailments affecting their lives and those of their family members. Everyday thousands of people visit faith healers and/or the shrines of dead saints in search of health and well being. For individuals and families with mental health problems, religious healing is often the first line of help (Saeed et al., 2000 ; Gadit and Khalid, 2002), although, these faith/folk healers may sometimes be consulted at the same time as other medical or alternative healers (Hilton et al., 2001).

Presently mental health care services in Pakistan rely heavily on the use of medication and physical therapy, such as Electro Convulsive Therapy (ECT), to treat mental distress. It is common for families to bring religious healers to hospital wards in order to carry out religious rituals or sometimes patients are removed from hospital in order to visit these healers. While the majority of people simultaneously use medical and religious healing, some choose to give

up psychiatric interventions completely and seek healing purely from religious sources.

The prevalence of mental health disorders in developing countries varies in different cultures. There is evidence that it is not only risk factors that differ in different cultures but also how common mental disorders such as anxiety and depression are conceptualised and the pathways to help selected (Patel, 2000). Developing an understanding of mental health in its cultural context is very important. It is these cultural beliefs and attitudes that determine help seeking (Kabir et al., 2004).

Religious and cultural teaching shapes explanations given to mental conflicts and experiences as well as providing guidance on how these issues can be addressed. There is an ongoing discussion in the scholarly literature regarding the concepts of religion and spirituality. Dein (2005) argues that both these concepts are culturally constructed. In the western world, the terms are recognised as two different entities; however, the situation may not be the same in a cross cultural context. This applies especially to Islam and Judaism where the spirit is considered to be part of the human being and the ultimate goal of human life is spiritual development to a level where the individual unites with the higher being.

In many non-western societies like Pakistan, persons are regarded as essentially linked to others. Concepts such as 'autonomy' and 'independence' are largely western values that define desirable ways of connecting with others. Consequently, in some societies, ideas about something being wrong or undesirable in a persons' functioning can differ greatly from western ideas. Lack of interdependence in non-western cultures is perceived to be an undesirable characteristic whereas lack of independence is perceived to be undesirable in Western cultures (Hahn, 1995).

DEFINING SOME TERMS

It is important at the outset to define some terms and concepts which will be repeatedly referred to throughout the forthcoming chapters. These initial definitions of culture; religion and spirituality; disease, illness and sickness; healing and cure; and patriarchy; should facilitate the reading and understanding of these terms as they appear in the main text.

Culture: a cultural system is a set of values, concepts, beliefs and rules that guide and rationalise people's behaviour in society (Hahn, 1995). Culture can also be seen as both the context and as an important determinant reflected in the behaviours, beliefs, and norms of individuals and those who are making decisions about help-seeking. In addition, culture is also reflected in organisations and their role in providing help and healing (Quah, 2007).

Religion: can be defined as “an organised system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/ reality)” (Koenig et al., 2001). *Spirituality*, on the other hand, is described as a personal quest for understanding answers to the ultimate questions about life, about meaning, and about relationships with the sacred. Spirituality as suggested by Dein (2005), emphasises “affect over cognition and experience over belief” (p. 529).

Spirituality and religiosity can be seen to connect a person to the universe and both can include striving for meaning and purpose in human life. Although religion is the practice of spiritual belief, spiritual concerns like searching for meaning in life can occur in the absence of any religious affiliation or practice (King et al., 2006).

Disease, illness and sickness are terms that are sometimes used interchangeably. However, they do mean slightly different things. For Kleinman

(1980), “disease refers to a malfunctioning of biological and or psychological processes; it affects individuals even when it attacks populations ... Illness involves processes of attention, perceptions, affective response, cognition and valuation directed at the disease and its manifestations” (p. 76). It also includes communication and interaction, particularly within the family and wider social network. “Illness is the shaping of disease into behaviour and experiences. It is created by personal social and cultural reactions to disease” (Kleinman, 1980 p. 76). *Sickness* is described as “an unwanted condition in one’s person or self – one’s mind, body or soul, or connection to the world. What counts as sickness is thus determined by the perception and experience of its bearer, the patient” (Hahn, 1995 p. 5).

Healing is considered by Kleinman (1980; 1973) as a system which aims to restructure, strengthen and support the bonds linking the individual and social experiences of illness. Healing, then is considerably more than an individual cure, it is also a social and cultural activity. In many traditional cultures, medically diagnosed illness is disorder, and healing is a socio-cultural activity by which chaos is transformed into order. Healing can also be described in terms of ‘restoration of a prior healthy state’, ‘rehabilitation’ and ‘the mitigation of suffering in the sick’ (Hahn, 1995 p.7). *Cure* on the other hand is defined by the Oxford English Dictionary as ‘to heal (wound or disease), to remedy or rectify, remove’.

Patriarchy is defined as “a form of social organisation in which cultural and institutional beliefs and patterns accept, support and reproduce the domination of women and younger men by older or more powerful men” (Levy, 2007). Any system that contributes to the social, cultural, and economic superiority or hegemony of men is considered to be patriarchal by sociologists. The culture of Pakistan represents classical patriarchy (Moghadam, 1992 ; Triandis, 2001).

Urdu words are used and italicised throughout the text where there is no clear equivalence or direct translation of the word or concept into English. The meaning of these is explained in footnotes and in a glossary provided in appendix 1

The following chapters outline a short ethnohistory of Pakistan, setting the context for the study which is crucial in understanding the culture, religion and world view of the participants. This is followed by a comprehensive review of the literature pertinent to the area under study. The research methodology outlines in detail, the method chosen for the study and details on the process of data collection and verification and the strategy for analysis.

The next chapter illustrates the findings from the study. Data collected both directly from the participants through the interview process and from participant observation are organised and presented in a thematic way. Following this, the discussion chapter considers the findings from the current study in more depth and in the light of the available literature. A theory of therapeutic encounter and transformation at the Shrine is proposed and explained. The final chapter focuses on the limitations of the study and makes a series of recommendations. These include how the findings can be used to enhance the provision of culturally competent care to those using health services both in Pakistan and the western world as well as developing understanding of the phenomenon of healing at a Muslim shrine.

CHAPTER 2: ETHNOHISTORY OF PAKISTAN

INTRODUCTION

This chapter presents a brief ethnohistory of Pakistan. The aim is to provide more detail in relation to the social and cultural context of the research and knowledge of the group to be studied. The areas covered include geographical and political profile, information about the population of Pakistan, and the current state of health services, particularly mental health services. I then go on to discuss Islam and its relevance to Pakistani society and the social structure, particularly focusing on the status of women. The chapter concludes with an explanation of Sufism and its relationship with Islam and the shrines of Pakistan.

It is hoped that this ethnohistory will set out the underlying foundations and context for the study that is to be described in the forthcoming chapters and assist the reader in understanding the complex social, cultural and religious society and place that is Pakistan.

GEOGRAPHICAL PROFILE

Pakistan is located in the north west of the Indian sub-continent. It is bordered by Iran and Afghanistan to the west, China to the north, India to the east and the Arabian Sea to the south. The name *Pakistan* is derived from the Urdu words *Pak* (meaning pure) and *stan* (meaning country) and it occupies an area of 852,392 km², which makes it almost three times as big as the United Kingdom (World Bank, 1998-1999, WHO, 2003, UK census 2001).

The land of Pakistan is diverse and includes snow capped mountains, rivers, swamps, plains and forests. About one half of the country's surface is covered by mountains including the three highest ranges in the world, the Himalayas, the Hindu Kush, and the Karakoram. The Indus River and its tributaries flow through the country from the Kashmir region to the Arabian Sea.

Pakistan is divided into four provinces namely Sindh, Punjab, Balochistan and North West Frontier Province (NWFP). In addition, a large area is federally administered, the tribal areas, Northern Areas, Islamabad Capital territory and the state of Azad Jammu and Kashmir. Each province is further sub-divided into districts – the main administrative units, which further divide into *tehsils and talukas* (Ghaffar et al, 2000). The climate varies enormously. The average temperature ranges from -25° C in the Northern Areas to 50° C in Sindh and the Punjab during summer.

Agriculture is the basis of Pakistan's economy with the major agricultural crops including wheat, rice, cotton, sugarcane, and tobacco. The Indus basin is instrumental in irrigating most of Pakistan's agricultural output.

POLITICAL BACKGROUND

The prehistoric Indus Valley civilization (c. 2500–1700 B.C.), was invaded by several groups including Aryans, Persians, Greeks, Arabs, Turks, before the Mogul Empire which ruled from the 16th to the mid-18th century. The British entered the region as merchants and in 1857, became the dominant power in the region. The unequal economic, social, and political holdings between Muslims and Hindus led to increasing dissatisfaction amongst the Muslims and to the formation of the Nationalist Muslim League (NML) in 1906 by Mohammed Ali Jinnah (1876–1949) (Infoplease, © 2000-2006).

Britain, following the support given by the NML during World War II, agreed to the formation of Pakistan as a separate territory within the Commonwealth in August 1947 and Jinnah became governor-general. The partition of Pakistan and India largely along religious lines resulted in the biggest migration in human history, with 17 million people fleeing across the borders in both directions.

Following independence, Pakistan remained as two separate regions, East and West Pakistan for 25 years before further division. Former Eastern Pakistan, now Bangladesh, separated from Pakistan in 1971 following armed conflict. Kashmir has remained disputed territory between India and Pakistan and continues to be a cause of major conflict between the two countries. Pakistan had its first elections under civilian rule in March 1977 where Zulfikar Ali Bhutto's Pakistan People's Party (PPP) were victorious. Dissatisfaction and growing resentment between different political parties led to a military takeover by General Mohammed Zia-ul-Haq and Bhutto was executed for the assassination of a political opponent in 1979. Pakistan was ruled by martial law until 1988, when Zia was killed in the midair explosion of his Pakistani Air Force plane. Elections at the end of 1988 brought long time Zia opponent Benazir Bhutto, daughter of Zulfikar Ali Bhutto, into office as prime minister.

From then onwards, Pakistan has seen frequently changing governments. Benazir Bhutto was prime minister twice and Nawaz Sharif three times, until he was unseated in a coup in October 1999, led by General Pervez Musharraf and nominal democracy was declared in June 2001. Asif Ali Zardari is the 11th and current President of Pakistan and the Co-Chairman of the PPP. He is the widower of Benazir Bhutto, who was assassinated December 2007, shortly before elections in early 2008.

POPULATION

The estimated total population of Pakistan is approximately 167 million, more than twice the UK population (60 million estimated. mid 2007). With a crude birth rate of 26.9 /1000 (2008 estimated) (Office for National Statistics, 2008 ; Infoplease., © 2000-2007), and crude death rate of 8/1000 population, there is a steady population growth rate at 1.8% of the population. Approximately 43.4% of the population is below 15 years of age whereas 3.5% is above 65 years (WHO- updated August 2004).

LITERACY AND EDUCATION

There has been a slow but progressive increase in the literacy rate among the Pakistani population. In 1980 adult literacy rates were around 13% for females and 40% for males. By 2003 this had risen to 30% and 59% respectively. However adult literacy rates may denote only the ability of an individual to read and write their name. All children in urban areas and most in the rural areas have access to primary education through government schools. However, scarce resource allocation for education seriously compromises the quality of education delivered in these schools. Although education in public or government schools at primary level is free of charge, expenses related to the purchase of uniform, books, equipment, recreational and practical activities and examinations is borne by the family. There is an increased demand and value placed on private schools (from kindergarten onwards) where children can access a better quality of education. There are a range of private schools catering to the needs of different socio-economic groups. Even families in poorer communities, earning as little as \$1 per day, try to send their children to private schools. On average a family may spend about 6.5% or 7.9% of their monthly salary per child on public or private education respectively (Alderman et al., 2001). Keeping in mind that the average number of children per household is 4.8, educating children often takes up a significant proportion of the household income. A majority of families also rely on private tuition for their children to supplement their education so that they can meet the requirements of the examination system.

HEALTH INDICATORS AND SERVICES

Total health expenditure as percent of Gross Domestic Product (GDP) in Pakistan was recorded as 2.4 in 2003. The per capita expenditure was US\$ 48 out of which governmental contribution allocated was about 27.7%. In 2003 however, governmental expenditure on health was equivalent to \$4 per person. About 98% of health expenditure in Pakistan was paid by the individual. In the

UK, health expenditure is 8% of GDP of which 85.7% comes from the Department of Health, which is roughly equal to US\$ 2,081 per capita (WHO, 2004 ; 2006).

The availability of human resources in the area of health in Pakistan presents rather a bleak picture. In 2003, the number of physicians per 10,000 population was 7.3 with even lower rates for nursing and midwifery personnel, which in 2004 was 4.6 per 10,000. In contrast, in the UK, in 2004, there were approximately 23 physicians and 92 nursing personnel for 10,000 populations. In Pakistan, the availability of hospital beds for a population of 10,000 is 6.8 compared to 36 acute beds in the UK. The 2004 Infant Mortality Rate per 1000 live births was 82 in 2002 in Pakistan whereas in the UK it was as low as 5.1 deaths per 1 000 live births. Total life expectancy is 63.6 years in Pakistan (63.7 for males and 63.4 for females) whereas in the UK it is 76 years (75 for males and 81 for females) (WHO, 2006).

Health care provision in Pakistan consists of private and government/public services. These services include general and specialist medical, surgical, and psychiatric residential and outpatient facilities. The private health sector may have social welfare services within an institution which dispenses discretionary financial help to assist the poor and those in need. Almost 70% of the population rely on the private health care system for their health needs (World Bank, 1993). The public health care sector comprises of the Basic Health Unit (BHU) and the Rural Health Unit (RHU) providing primary health care services, Tehsil hospitals serve as sub district hospitals and work with district hospitals focusing mainly on tertiary care. In 1995, there were a total of 22 district hospitals in Pakistan. The unstable political situation and changing health budget has, however, left these facilities with very limited resources, human and material. Less than 30% of people use primary health care facilities which means that on average there is less than one visit per person per year (Ghaffar et al., 2000).

Institutions in both the private and public sectors are making conscious and constant efforts to improve the health status of the people of Pakistan. However, resources allocated by the government are not effectively or efficiently utilised due to frequently changing authority and deeply embedded corruption. People admitted to public hospitals are required to pay nominal charges for their bed and the medications they receive. Private health services are major health resources for the public in Pakistan despite requiring patients or families to pay for treatment (Karim et al., 2004). Families are informal health resources bearing most of the physical, emotional, technical, as well as financial burden of providing care. The ever declining health budget in Pakistan limits state funded health agencies' ability to provide quality care. For example, in 1999, the percent of GDP spent on health was 3.7% which went down even further to 2.4% in 2003 (World Health Report 2006). This situation often leads to the over-burdening of the family or people being left untreated (Gadit, 2004).

MENTAL HEALTH SERVICES

At the time of partition in 1947, Pakistan had only one mental hospital in Lahore which was built in 1940. In addition, a Parsi (Zoroastrian) philanthropist donated a small institution, in Hyderabad, built in 1865 to be used as a mental hospital for the province of Sindh. With the development of new national health services, it was decided that smaller psychiatric facilities should be built in teaching hospitals and psychiatric care should be delivered from general hospitals rather than separating them and placing institutions on the outskirts of towns.

At present, specialist psychiatric services are available in most of the teaching hospitals, mostly located within general hospitals and providing services for adult admissions. There are only three old asylum style hospitals which are gradually being changed into hospital or community based facilities. There are a total of 2154 psychiatric hospital beds in general hospitals and an additional 943 beds available in the three asylums. There are no specific beds for child

psychiatry, drugs/alcohol, or any other sub speciality. All of these hospitals are in urban areas making them largely inaccessible to people from rural areas (Mubbashar and Saeed, 2001 ; Gadit and Khalid, 2002 ; Karim et al., 2004). There are about 150-200 qualified psychiatrists in Pakistan, making it a ratio of 1 psychiatrist to a million people. Except for a few medical education institutions, psychiatry is neither taught nor examined at undergraduate level, often leaving doctors poorly qualified to deal with people with mental health problems (Khan, 2006).

In addition, a number of psychiatric clinical and inpatient facilities are available in the private sector, whose fees are borne by patients. These facilities provide care to clients with a wide range of mental illness, however, malpractices and abusive treatment is very common. The quality of psychiatric services in the public sector is generally poor and limited human and material resources make it even harder for the distressed to access services. The care on offer is custodial and the presence of very few, often inexperienced and unqualified staff members, the lack of security for patients and for staff, and a total reliance on the psychotropic medication available, hardly provides a rehabilitative experience for patients already experiencing mental distress (Gilani et al., 2005). Family members often stay with the patient in the ward and take responsibility for providing personal care.

As there is minimum regulation around the sale and dispensing of medications (except narcotics), psychiatric medications (antipsychotic, antidepressants, benzodiazepines etc) can easily be bought without prescription. This results in a situation where the prescription of psychiatric medications, and their use and abuse by patients or the general public cannot be monitored. In my experience, one can buy most medications in bulk without any permission or prescription to do so. Often, people present to community clinics or emergency rooms with severe extra pyramidal side-effects due to neglect and the indifferent attitudes or ignorance of health professionals in prescribing psychiatric medications.

In India, the voluntary sector (non governmental organisations) has made efforts towards promoting mental health and effective care for mental health problems and have succeeded in developing a sustainable structure (Thara et al., 2004). Pakistan however is still struggling with funding in the voluntary sector and remains under-developed in this area.

As with the education system, people rely heavily upon private health services. The admission of an individual to a private mental health unit often depends upon the patient and/or the family's ability to pay. Similarly an inability to pay may lead to premature discharge from the hospital, often without complete recovery. Until recently, mental health care was underpinned legislatively by the Lunacy Act of 1912 which has now been replaced by the 'Mental Health Ordinance 2002' (Gilani et al., 2005). Although the ordinance emphasises the need for community management of mental health problems and brings in the concept of voluntary admission to a psychiatric facility, the decision to bring a person to hospital largely remains with the family (Deva, 2002). Limited facilities and mental health care have also led to vulnerable people being used for criminal activities and ending up in prisons. Some philanthropists, like Abdul Sattar Edhi, have developed residential facilities to house the homeless and abandoned mentally ill. However, the quality of care in these institutions has been a cause of concern among health professionals in Pakistan and raises many questions (personal experience).

The constant challenge posed by the low literacy level among Pakistanis, especially among women in the rural areas, acts as a major barrier to the dissemination of health education through printed media to those who have limited access to health facilities. Various social and health organisations have joined with the government of Pakistan and other international development organisations to enhance social development and initiate programmes including poverty alleviation, adult literacy and school based health promotion.

Community based provision of health care services is a model advocated to meet needs in developing countries. In Pakistan and India, low budgetary resources, competing healing systems, scarcity of mental health professionals and stigma related to mental illness has led to mental health being a low priority for governments (Thara et al., 2004). The failure to develop and maintain the infrastructure for primary health care and to provide affordable health care for all sections of the community has resulted from the poor quality of training for health professionals, high costs of psychotropic medications and corruption. This situation has led to an increasing use of and reliance on non governmental and private providers, meaning that individuals often have to purchase medicines and local health care and a significant proportion of overall health care costs are borne privately. The rates for use of private health care are as high as 77% in Pakistan and 87% in India (James et al., 2002).

LANGUAGES

The national language of Pakistan is Urdu. English however, dominates as an official language in government as well as the private sector. In addition to Urdu, each province has their own language i.e. Sindhi (Sindh), Punjabi (Punjab), Baluchi (Baluchistan) and Pukhtoon/Pushto (NWFP). It is mandatory for all the schools to teach the national and provincial languages as well as English. Several other spoken and written languages within each province remain popular locally. People from each province will generally speak and understand some level of Urdu.

SOCIAL AND WELFARE SYSTEM IN PAKISTAN

Providing care and financial support to elderly parents is the moral and religious responsibility of children in general and sons in particular. Sons are also eligible for a major segment of inheritance compared to daughters. The State does not provide any social welfare support or pension to its people except for some funds provided through the annual collection of Zakat. Zakat is a

compulsory charitable requirement in Islam where 2.5% of all worldly goods which are accumulated over a period of one year are given to charity. This charity can be dispensed on an individual basis as well as through some nominated authorities in the government or otherwise, to those considered 'deserving' (*mustehqeen*) (Karim et al., 2004). There are complex rules around who is deemed eligible to receive Zakat donations; however, people who are poor and needy and unable to earn their living are included.

RELIGION

Islam is the second largest religion of the world and has an estimated 1.2 billion followers living in over 200 countries. Of those countries, 45 are considered to have a Muslim majority. The size of the Muslim world and magnitude of its followers demands that its belief system, practices, social and political trends are recognised, understood and acknowledged. The 1998 Census in Pakistan estimated 96 percent of the population to be Muslim; 1.69 percent Christian; 2.02 percent Hindu; and 0.35 percent were classified as "other". The majority of Muslims in the country are Sunni and subscribe to the Hanafi School of Islamic law (Hassan, 2002). Since independence, Pakistan has developed as an Islamic Republic.

ISLAM

All Muslims are required to hold and adhere to a basic belief system. Sociological discourses describe them as warranting, purposive and implemental beliefs. Warranting beliefs describe the existence of Allah and his character, purposive beliefs explain the purpose and believer's role in regard to that purpose, and implemental beliefs provide an ethical and moral framework for practising the religion. According to Bell (1997), rituals play an extremely important role in the maintenance of any institution, community, and religious identity. Participation in these rituals provides an individual with 'unconscious appropriation of common values and common categories of knowledge and

experience' (cited in Hassan, 2002). In Islam, Muslims are expected to engage in a variety of rituals in order to express their faith. These include daily '*salat*' (prayers) and *wudu*' (a sequential cleansing of body parts prior to prayers). Muslims are expected to offer 'Salat' five times or more each day, recite the Holy Qur'an¹, fast in the holy month of Ramadan, pay annual charity (*zakat*), and make a holy pilgrimage to Mecca at least once in a lifetime. The devotional dimension of Islam is close to the ritualistic aspect and includes personalised religious devotion and the expression of religiosity at an individual or collective level. It may include personal prayers and consulting the Holy Scripture to find answers to the problems of daily living.

Hassan (2002) considers the cognitive dimension of religiosity to be its experiential aspect. The experiences of ultimate divine reality, love, fear, trust or faith all make up part of this dimension. In Islam, Sufi traditions and folk or popular Islam has placed an emphasis on changing inner states by 'tassawuf' or personal religious experience which bridges the gap between the human being and the divine power. The followers of each religion mould their lives according to the rewards and punishment declared by the religious teaching upon commitment of certain acts. There are a variety of immediate and long term rewards which have been promised in Islam, for instance, total submission to Allah and religious paths prescribed by the Qur'an, *Hadith* (teaching of the Prophet Muhammad PBUH) and *Sunnah* (examples from the life of the Prophet Muhammad PBUH) may result in happiness, peace and success in this life and spiritual salvation and heaven in the next.

Different paths of Islam are followed in the contemporary world. Countries like Libya and Tunisia are open to *Ijtihad* (interpretation) and encourage discussion of faith issues whereas others insist that avenues for discussion and

¹ Qur'an is the religious text of Islam. Muslims believe the Qur'an to be the book of divine guidance and direction for all human beings.

interpretation closed 1400 years ago with the death of Prophet Muhammad (PBUH). There is no consensus among the Muslim States as to how Islamic laws should fit into a contemporary institutional framework. Like other religions, Islam is not attached to only a small group of people based in a small geographical location; it applies to a very diverse people and populations. As people and their indigenous customs differ, so too do interpretations, and therefore even the acceptance of the possibility of interpretation of the religious legal code. What is accepted as doctrine is often a combination of indigenous cultural values and mores combined with the type of interpretation of Islamic law prevalent in that area (Weiss, 1985), although most often it is perceived to be the 'teaching of Islam' rather than the influence of culture.

CHARACTERISTICS OF ISLAMIC CULTURE AND ITS PLACE IN PAKISTAN

Religion is closely intertwined with a person's way of living in Pakistan. It shapes a person's ethnic, social, and economic identity. Five times a day prayers for Muslims are a firm part of their daily routine and structure. Traditionally only men in Pakistan can offer their prayers in a mosque and women pray at home or in the workplace. Only recently a large mosque in the capital, Islamabad, has built a separate section for women to offer their prayers in the mosque. Afternoon prayers on Fridays are special and most men gather in mosques to pray in a large congregation. Most of the offices close for an extended break to facilitate attendance at the mosque. During the holy month of Ramadan, many otherwise less vigilant Muslims fast and attend mosque services more frequently. There is also an increase in attendance at religious institutions for additional prayer ceremonies and increased charitable contributions are made.

Islamic societies around the world share common features which distinguish the culture from others. These include 1) interdependence and loyalty within the family; 2) hierarchy and patriarchy in society and respect for authority; 3)

collectivity in society where an individual's behaviour is assessed against the norms, roles and goals of their collective environment rather than personal choices, rights, likes and dislikes; and 4) the maintenance of traditional practices where cultural change is considered threatening (Pridmore and Pasha, 2004).

Social customs are influenced by the teaching of Islam, yet with rapid modernisation and exposure to the wider world, values are changing. People are very conscious in regard to their social traditions and make significant investment in maintaining social prestige and respect within the social system. Respect for elders and close relatives, hierarchy within relationships and classes, modest dressing, limited display of emotions towards one's partner, and male domination are some examples which are desired by the majority and contribute significantly to maintaining a social system in Pakistan. Exposure to media, the rapid influx of information from the West and the increased mobility of Pakistanis within the western world has affected cultural and social values and become a source of conflict between people with more orthodox beliefs and those embracing change. Living within the moral principles of Islam is valued and adultery and outward displays of sexuality can have fatal consequences (Khan, 2003 ; Murshid, 2005).

POSITION OF THE FAMILY IN SOCIETY

FAMILY SYSTEM

The family unit in Pakistani society is responsible for the total care of its members. Without social services or a welfare state, families try to adopt strategies to maintain and strengthen the family unit. Pakistan is broadly a patriarchal society and inegalitarian as far as gender relationships are concerned. Men receive privileges, respect, honour and decision making authority. Most households and families are usually headed by a male, who has the power to make decisions for the whole family (Khan, 1999 ; Rahim, 2000 ;

Jejeebhoy and Sathar, 2001). In many situations upon the death of the male head of the family, younger males take up the position of decision maker. Older members in families are generally given positions of respect and honour and are cared for by younger members. A joint family system prevails in most communities. Women join the households/families of their husbands after marriage often at an early age, whereas sons expand their families by bringing their wives to the home and carrying on generations (Sonuga-Barke et al., 1998 ; Jejeebhoy and Sathar, 2001). It is common for single or widowed women to join their families or relatives (immediate or distant) and may often contribute by taking care giving or house keeping roles within the family as part of a reciprocal arrangement. Young children, often from rural areas are sometimes informally adopted by other relatives in cities to enable them to access education and in return provide some domestic help to the family.

STATUS OF WOMEN IN PAKISTAN

Men assume the role of protector of female relatives both within the household and outside. This role often gives them the authority to make decisions for women in all aspects of their lives. The role is frequently justified by citing references from the verses of Qur'an. However, it has been suggested that there is a reinterpretation of the Qur'an to suit male socialisation and maintain their dominant position in the family system and society in general (Rahman, 2004). It is also suggested that excerpts from the Qur'an are widely misinterpreted to justify men's supremacy and control over women. One such example is polygamy, which is allowed in Islam, provided the husband is able to treat all wives with equality and justice. However, it is used to promote promiscuity and often becomes a threat to women to encourage them to continue providing for their husbands sexually (Rabbani et al., 2008). This reinterpretation of Qur'anic teaching gives men control over women's life choices, ultimately making women responsible for maintaining the honour and respect of the whole family.

The most apparent restriction placed on women comes from the system of *pardah*, which segregates women from the world of men. *Pardah* literally means "curtain" in Urdu, it has come to connote both the physical and practical separations between the activities of men and women. Although use of *pardah* is not consistent among all women, its use is often associated with women's role in preserving the family's izzat (honour) (Weiss, 1985). It is often men who assign these values to the familial roles women assume. However, if women decide to break with convention and not assume the required role, the implications can be severe (Khan, 1999). Any behaviour by female family members, which is thought to create a negative perception of the family is worthy of blame. This blame induces guilt in the women and is a cause of oppression (Hassan, 2002). This pattern is often criticised by feminist analysts as the focus is not essentially to protect females but to protect the relationship which binds a woman to a man (Rahman, 2004).

There is strong parental control over decisions in regard to the marriage of children, especially for women. The decision to marry is often influenced by factors such as the availability of a prospective mate, the feasibility of the marriage (ability to support financially) and the desirability of the marriage (consideration of social and sometimes financial, rewards and penalties upon entering or not entering the marriage). Gayle Rubin (1975) points out that marriages are a form of exchange between kin groups in which women are a gift that allows kin groups to build alliances and become related by blood. Women are not partners in these exchanges and therefore are not allowed to participate or be a beneficiary of the exchange (cited in Khan, 1999). Daughters can be taken out of school at a very young age if the parents decide to marry them off or the decision to marry can be delayed if the assistance of the daughter continues to be required at home (for instance, in care giving or in generating income). A world fertility survey of the mid 1970s revealed that almost 87% of women in Pakistan were first married between the ages of 10 to 19. Changes have however taken place in fertility trends and ages of marriage for women. The mean age for

women at the time of marriage in 1998 had risen to 21.7. This change is significantly correlated with the acquiring of education above elementary level (Chowdhury and Trovato, 1994 ; Sathar, 2001).

The status of women is also affected by geographical location. Those living in less populated or rural areas have more severe restrictions placed upon them. They are expected to comply with the tribal rules and deviance from them, especially cross gender socialisation can be severely penalised (Niaz, 2003 ; Husain et al., 2007). Women are in a position where they are expected to abide by the rules and meet the expectations set by male members of the family (Jejeebhoy and Sathar, 2001 ; Niaz, 2004).

Generally there is a lack of control over life decisions among women. This is exemplified by early marriages, high expectations of newly married women to conceive and poor access to contraception. Those producing sons have a higher status among women. Mothers of girls and those without children experience harassment, emotional and physical abuse and live subordinate lives (Winkvist and Akhtar, 2000)

The Islamic religion, in fact, grants many rights to women, including the right to own property, consent in marriage, and remarriage by widows and divorcees and to inherit (Weiss, 1985). It is suggested that Hindu culture and its patriarchal system were absorbed over time by Islam and passed on such values as female inferiority (Rahim, 2000 ; Niaz, 2003). According to Murshid (2005) the author in the Islam which is practiced in most of the world today, patriarchy is institutionalised thus promoting inequality and the suppression of women, denying women's rights of inheritance, divorce, and marriage. These practices and interpretations have been set by social rather than legal parameters.

WOMEN AND WORK

Approximately 75% of women live in rural areas and the average Pakistani female is burdened with illiteracy, constant motherhood and poor health (Niaz, 2003). Women make up only 28% of the country's labour force (World Bank, 1997). In general the educational attainment of women is lower than men and there is a significant age difference between husbands and wives, the husband being older. Women are involved in full-time, unpaid work in the home and reproduction takes place only within marriage. Women are still economically dependent on men and this dependency gives a greater level of control to men over decision making (Fikree and Pasha, 2004). Women take responsibility for household maintenance and child care, and are primary carers for elderly relatives. They are generally not encouraged to go out of the house to find employment but to take work which can be performed at home, e.g. sewing, cooking or giving private tuition to children. This is so as not to risk losing respect or dishonouring the family name in the community. In rural settings, a significant proportion of women also engage in non-wage earning agricultural labour on the family land or to the livestock. The visibility of women working outside the home may lead to male relatives being considered inadequate in terms of their ability to provide for their family and result in a loss of face and prestige in the community (Fikree and Pasha, 2004). Women's involvement in paid employment is discouraged by males, probably because of the possibility that it could provide a level of economic independence for the women and consequently a demand for their own rights. Douki et al (2007) suggest that women's work is a fundamental threat to men's superiority in the Islamic world. Patriarchy in Pakistan operates on rigid rules which clearly define the place of men and women (Mumtaz et al., 2003). The rearing of children therefore reflects preparation for the role each will assume as an adult. Women are prepared to bear and rear children within primarily a joint family system, and being a mother requires them to please others, and sacrifice their own needs (Khan, 1999).

Recent trends, however, have seen a rise in female employment both inside and sometimes outside the home, although this employment may not necessarily impact upon their autonomy (Sathar, 2001). This has, in turn, brought some changes to the family system. Although the additional income is welcomed, in many social classes women hand over their wages to the husband or in-laws who then use it at their discretion (Mumtaz et al., 2003). It also brings with it an increased workload for women, where they maintain complete responsibility for their household duties as well as their job. Men continue to assume their authority as primary or sole decision maker despite the change. In times of sickness or crisis in the family, women are expected to make arrangements to deal with any additional responsibilities.

Those who have no choice but to work sometimes respond by adopting cultural practices which emphasise their modesty in order to protect or shield themselves from public exposure. Veiling is one example of this when a woman seeks to protect her honour so that she can still expect the level of protection and security that is promised in classical patriarchy. According to Azari (1983, p. 68), “the restriction imposed on them by an Islamic order (for the veil) was therefore a small price that had to be paid in exchange for the security, stability and the presumed respect this order promised them” (Quoted in Kandiyoti, 1988). Beliefs about a woman’s vulnerability and tendency to engage in ‘inappropriate’ and ‘immoral’ activities result from perceptions held by some Muslims who consider women to be half-human and half-devil whereas men are believed to be half-human and half-God (Rahman, 2004) Women are generally considered to be individuals who need assistance, advice, and protection in their lives from men (Khan, 1999 ; Winkvist and Akhtar, 2000).

PREVALENCE OF DOMESTIC VIOLENCE

Domestic violence, sexual harassment, sexual violence both within marital relationship and from acquaintances and strangers, and the physical and sexual abuse of children are prevalent in Pakistani (Hassan et al., 2007 ; Hussain and

Khan, 2008). Embarrassment and the perceived threat to the honour and respect of the family from reporting violence mean that women are reluctant to do so (Hassan et al., 2007).

Misinterpretation of the Qur'an by ignorant religious scholars over centuries provides the justification for a degree of violence perpetrated by men against women in order to assert social control and supposedly bring harmony to family life. The interpretation of the verses of the Qur'an (verse Al-Nisa, 34), often used to justify this violence has been questioned in several pieces of literature clarifying the role and place of women in Islamic society (Rehman, 2004). A single word in Arabic has several meanings. The Qur'an can therefore be interpreted in a manner suitable to the maintenance of a patriarchal society and male dominated culture. Often women find themselves in a culture where they also contribute to the oppression of other women for example, a mother in law who contributes to domestic violence by instigating or perpetrating it. It is common to find these women justifying their behaviour on the basis of 'protection of families' or 'doing their best for their families' or to gain 'approval and love' from their sons (Jejeebhoy and Sathar, 2001). Many women who are victims of domestic violence accept the violence as they view men as superior due to their ability to work outside the home and earn money for the family (Douki et al., 2003 ; Niaz, 2004 ; Douki et al., 2007).

Rabbani et al (2008) suggest that the social causes of domestic violence relate to economic backwardness, insufficient legal protection, low educational levels, a patriarchal society and the low social status of women. Niaz (2003) presents a detailed account of violence against women in the form of physical, emotional, and sexual abuse, kidnapping, honour killings, murders, suicides, dowry violence, and violence in custody. According to the author, violence against women can be understood in the light of three theories. The first is ingrained cultural beliefs and attitudes towards women viewing them as 'visitors' who would go to their real homes (after marriage) and therefore without rights and

with no need to be given opportunities to learn many life skills. The second outlines the mentality of male chauvinism of which expression of anger is the main element and the third suggests that men use women as an outlet for expressing their frustrations and disappointments.

The Pakistani police who have a duty to protect the rights of citizens from violence frequently become the perpetrators. Women escaping from family control and coercion find the police and the State to be corrupt colluders in the violence and abuse perpetrated against them (Khan, 2003).

HEALTH AND CULTURAL BELIEFS AND HEALING PRACTICES

Religio-cultural practices significantly influence how health problems are perceived and addressed. The knowledge behind these health perceptions and practices is not always written and often passes orally from one generation to the next. Farooqi (2007) explains that the word Islam originates from the Arabic word 'Salaam' and when translated literally from Arabic to English can be understood as surrender. This "does not mean passivity or attitude of submission, but a continued volitional effort to attune oneself to the eternal realities of which the focus is Allah (p. 402)." According to the author this deep acceptance of being in relation to Allah is health promoting and has healing qualities.

Pakistani culture is a mixture of rituals, traditions, and folk beliefs. The belief system underlying causation of illness and healing regimes is complex and multilayered. Explanations of illness include possession by jinn, ghosts or fairies; evil spirits; black magic spells and healing approaches including exorcism, sorcery, faith and traditional healers including long dead Sufi saints. Often the rationale behind these beliefs is again believed to be rooted in the Qur'an and *Hadith* (Yousaf, 1997 ; Qidwai et al., 2002 ; Gilani et al., 2005 ; Farooqi, 2007).

Some common traditional healing methods used in Pakistan are described below (Farooqi, 2007)

- a) Homeopathy – a method that clinically applies the law of similarities and uses medically active substances in insignificant doses
- b) Unani tibb or naturopathy – uses herbs to fight ailments of any sort, these counteract the opposite abnormal quality in the body or any of its organs, or evacuates, alters, strengthens, or tones up as the case may be
- c) Islamic faith/spiritual healing – helps individuals clarify their values and work out a meaningful way of being in the world; that is, submission to the will of Allah and adherence to the teachings of the Qur'an and *Hadith*.
- d) Sufi saints – the bond between the saint and their followers facilitates empathic understanding, catharsis and insight into ones intra-psychic and interpersonal conflicts
- e) Sorcery – uses black magic and claims to have extraordinary powers through which a person can hurt or helped. The therapy includes the sorcerer identifying and naming the problem as magic and carrying out rituals to counteract the magic in return for cash or other offerings.

In addition, some healing or protective practices which are integrated into everyday life include

- a) Ta'awiz or Talisman a small piece of paper, with a chosen verse from the Qur'an, encased in metal covering, tied with a thread to be put around the neck or upper arm. These reportedly provide protection from evil spirits and bring good fortune. Mostly given by a religious leader in return for a small donation
- b) Holy water is taken in a container to a religious leader who reads Qur'anic verses over the container or gives a ta'awiz which is soaked in a jug of water and the 'one in need' drinks water from it.

- c) Soil from holy places [shrine, mosque] can be taken from the premises and can either be rubbed gently on skin to alleviate pain or sprinkled in the house to protect it from the evil eye and magic.
- d) Visits to shrines and the offering of money, food or sweets to the poor or needy.
- e) Recitation of *Hamd* (songs to praise Allah) and *Na'at* (songs to praise the Prophet Muhammad [PBUH]).
- f) *Mannat*, the making of a promise to a holy man or to Allah to make certain offerings in the event that a wish is fulfilled.

MENTAL HEALTH PROBLEMS IN PAKISTAN

Epidemiological studies carried out in Pakistan show that 10%-66% of the population are suffering from mild to moderate mental illness whereas serious mental health problems like schizophrenia, bipolar disorders and dementia constitute another 1-2% (Mubbashar and Saeed, 2001 ; Gadit and Khalid, 2002 ; Gadit and Mugford, February 2007). An economic survey of Pakistan in 2001 showed a significant increase in the numbers involved in drug and substance misuse from 1.9 million in 1986, the number of drug users had risen to at least 4.0 million by 2000, the vast majority of them young men, out of which more than 50% used heroin (World Health Organisation, 2001). With existing health budgets, the main focus of the primary health care system is on reducing rates of infant and maternal morbidity and mortality. In cases where an individual or family consider mental distress to be mental illness/disease, typically a general practitioner (GP) will be consulted.

SUFISM

The tradition of healing at a shrine, which is the focus for this study, is closely associated with Sufism. I will therefore present an overview of this area including its origins, the history, and principles of Sufism and its relevance to

my study. The Arabic word Sufi has been used in many ways over the centuries. Modern scholars have agreed that the original meaning of the word Sufi was “one who wears wool” however; later in the 8th century it was applied to describe people with ascetic inclinations who wore rough and uncomfortable garments. Gradually it was assigned to a group of Muslims who differentiated themselves from other Muslims by emphasising certain teachings from the Qur’an and *Hadith* (Chittick, 2000).

Sufi orders started well before the 10th century for the purpose of spiritual training in the region of modern day Iran and Iraq. Different orders of Sufis found connections with each other or to the prophet Muhammad (PBUH) through Hazrat Ali, the fourth Khalifa, and Hazrat Abu Bukur, the first Khalifa after the death of Prophet Muhammad (PBUH). By the 10th century, Sufism had several different branches or orders which were led by Sufi teachers/ leaders (Burton, 1980).

Historically Sufism was described as a ‘pathway to God’. The aim of Sufism is to eliminate all the barriers between man and God through changing patterns of life. The wisdom of Sufism is found in their teaching, often appearing as books, poetry, dancing, art, calligraphy and prayers. Sufis believe that the divine power of God permeates the whole universe and it is through mysticism, that one can begin to see the beauty of God, find true love for the creator, and eventually achieve oneness with the creator (Dhaul, 2004). In Sufi philosophy, reality is the universal will, the true knowledge, eternal light, and supreme beauty, whose nature is self manifestations, reflected in the mirror of the universe (Burton, 1980). The word ‘*sama*’ is also used to mean ‘listening to music’ and by extension ‘music’. By the end of the ninth century listening to music or ‘audition’ had become a practice performed by some Sufis and typically followed dancing. The practice of dancing was considered contrary to the principles of

*Sharia*². Music was crucial in transporting the Sufis to the invisible world of their very origin, a place of non- existence, a realm where God is still speaking His eternal word directly to them. The term ‘whirling dervish’ is often used to describe Sufi dancing and entered the West through tales from Middle Eastern countries (Chittick, 2000).

The Indian subcontinent was one of the five great centres of Sufism; the others were Iran, Mesopotamia, Syria, and North Africa. The first two Sufi orders were established in the 13th century, and were the Chishti and Suhrawardi orders, and these were followed by the Qadri order in the 15th century. The fourth great Sufi order, the Naqshbandi began in the sixteenth century (Pfleiderer, 2006).

In principle, Sufism does not take into consideration ‘*karamat*’ (*ability to perform unusual actions*), or ‘miracles’ often attributed to saints. The whole philosophy is based upon achieving nearness with God, and complete neglect of the worldly needs of the self. Highlighting the self and claiming miracles defeats the original purpose. Sometimes however, the follower perceives the influence of spiritual *karamat* as a result of their intense devotion. In this case Sufis would redirect followers to return to the essence of Sufism and its teaching (Nurbakhsh, 1978 ; Werbner, 2003).

RELATIONSHIP BETWEEN PIR AND MURID

Saints, their shrines, their congregations where its mystic music led followers to experience closeness with Allah brought about an amazing growth in Sufism and a different kind of experience from that of a general believer in Islam. It also brought a new relationship between *Pir* (the Sufi Saint/teacher) and *murid* (the disciple/follower). Sufi teaching was based on the premise that the *Pir* is

² Sharia is the body of Islamic religious law. It is the legal framework within which the public and private aspects of life are regulated for those living in that legal system. *Sharia* deals with many aspects of day-to-day life, including politics, economics, banking, business, family, sexuality, hygiene, and social issues.

never questioned or doubted and total surrender and submission is practiced. The *murid* looks at the *Pir* as an intermediary between Allah and him/herself and looks up to him to solve all his/her everyday problems (Islam, 2002). Under Sufism the *murids* were prepared until they were able to annihilate themselves in their *Pirs*, prior to annihilating themselves in God. During this process, some *murids* however, were redirected and began to attribute changes in their environment to the process of spiritual upliftment. They attracted a group of followers. These followers then spread stories about their *Pirs*, thus attracting further attention and reputation (Nurbakhsh, 1978 ; 1978). Once Sufism had become organised into orders, its following began to grow. The figure of the *Pir* or *sheikh* emerged as a dominant figure, to be revered, loved, remembered, and appealed to for help and security. The death of the *Pir/ Sheikh* rerouted the target of love and submission towards the grave and *durgah* (shrine) of the *Pir*, a physical reminder and symbol of the *Pir*.

TENSION BETWEEN ISLAM AND SUFISM

The popularity of Sufism was linked to the Sufis' ability to relate to common people and by offering them spiritual experiences in return for total obedience and surrender. Islam (2002) however suggests a number of reasons for the eventual decline of the tradition. Blind surrender to one's *Pir* has been criticized as it can colour devotees' perceptions of daily life events, family relations, and social interactions. He also quotes one example where a follower prayed and wished his son to be dead so that he could engage in total concentration with his *Pir* without having to worry about worldly relations or concerns.

Such immersion of the *murids* into following their *Pir* ensured that they lived their life as absolute devotees of Islam. Islam (2002) points out that the heavy emphasis on the relationship between *Pir* and *murid* is contrary to monotheism, which is the backbone of Islam. Any act or behaviour showing otherwise is considered blasphemous and therefore unacceptable. A wide range of examples can be found in the Sufi literature describing the nature of the relationship

between *Pir* and *murid* ranging from blind obedience to independent discernment. However, the majority of the literature favours unquestioning obedience.

Sufi tradition creates conflicting reactions among Islamic sects and societies. Shrines in the Indian subcontinent as the heritage of Sufi Saints have existed for centuries. More traditional Muslims have claimed that Sufi practices are against the original principles of Islam and heavily influenced by Christianity and Hinduism. There are mixed feelings concerning praying to the Saint at the shrine as it is perceived to be in conflict with fundamental Islamic beliefs concerning *shirk* (polytheism).

Attitude towards family and marriage is another area which has been highlighted by Muslim critics. Strict celibacy was practiced by only some of the Sufi masters but there are many examples where the Sufi masters or followers turned away from family life, divorced their wives soon after marriage and remained indifferent to the presence of illness or accidents in the family. Owing to their ascetic origins and traditions, literature reveals that many Sufis encouraged their devotees to shun human society and detach themselves from it and to immerse themselves completely in spiritual development. This was considered contrary to the Muslim tradition of sociability, togetherness and family life (Islam, 2002).

Kasb (earning one's own livelihood) and *futuh* (unsolicited charity) were two other areas which have been identified as unhealthy traditions in the practice of Sufism. Some Sufi orders devalued *kasb* and promoted *tawakkal* (trust in God) and placed the two in opposition, this is where the practice of begging (*zanbil*) also began. Islam (2002) describes how an engagement in *kasb* was seen as a sign of lack of trust in God and therefore devalued. Other Sufi orders however, placed a higher importance on earning for self (*kasb*) relating it with the practice of the Prophet Muhammad (PBUH).

The practice of accepting *futuh* (unasked for-charity) was encouraged by Sufis and relates to the principle of generosity in Islam. However, critics blame the tradition of *futuh* at *khanquah* or at the shrine of the Sufi saints which made people dependent on these places for their income and survival. Islam (2002) also suggests that this system was responsible for encouraging dependency on the shrines after the Sufi was dead. As long as these places are visited and considered sacred, *futuh* can be collected by the *mujhavers* (caretakers) and *khaadim* (servants) of the shrine.

Perceived threats to monotheism, the detached attitude towards marriage and family, and contradicting views about *kasb* and *futuh* were some of the reasons for the decline in popularity of Sufism in the Islamic world. According to Islam (2002), the decline began as early as the 10th century which was also considered the time of its rise and growth. It is said that corruption seeped into Sufism from early on and the symptom of decay became more pronounced over time.

POSITION OF SUFIS IN PAKISTANI CULTURE

In Pakistan, children are socialised from an early age around beliefs in Saints and their *karamat*, rather than it being a chosen affiliation. Some families, communities, or villages have adopted a Saint and followed rituals at shrines for centuries. Sermons by visiting religious leaders, tales from elders in the family and reported miracles from visitors to shrines serve as sources of learning about saints and their miracles.

Shrines are associated with healing as these are places where saints are buried, saints who spent their lives gaining spiritual powers and achieving closeness with Allah. Paying respects to the saint by means of making regular visits is a common practice. Those with stronger beliefs in the Saints and their spiritual powers, justify using them as an intercessory to convey their requests for healing to Allah (Werbner, 2003) .

SUFI SHRINES

According to Islam (2002), people can find a higher level of spiritual experience by relating with Sufism, but what a common Muslim found was an attachment to a person 'the Sufi' and nothing beyond this. Due to the commitment to the person and not the principles of Sufism, spiritual attainment among *murids* decreased as the fixation on the Sufi guide/teacher became stronger. Instead of investing in spiritual training, devotees surrendered to acts of obedience. Also, for most of the *murids*, *Pirs* became resources where they could find solutions to the mundane problems of daily living. Some *Pirs* encouraged this dependence by cultivating unquestioning faith and blind surrender thus decreasing direct contact for the devotee with Allah. Many Sufis reassured their *murids* that after their deaths, their shrines would continue to provide them with shelter, food and a platform from which to continue religious activities. The system of shrines and their popularity among the people of south Asia continues even after several centuries. The shrines or mausoleums (*durgah* in South Asia) were and still are visited by thousands of people. They still pray for solutions to their own problems and those of their families or loved ones (Islam, 2002).

At the present time, the shrines of late Sufis in the Indian subcontinent attract people from all strata of society. Although Sufi training has come to an end, the followers of Sufi saints from all over the Indian subcontinent pay their respects at different shrines. They present their *futuh*, show their devotion, and plead for the fulfilment of their wishes and healing of their ailments. These late saints are given the status of 'intermediary' between the individual and Allah. The followers experience a connection and communication with the dead saints and instructions for promoting health and improving the quality of their life. Total surrender and blind faith are considered an absolute requirement if healing is to be achieved (Hassan, 2002).

In Pakistan, over the last decade, the government of Pakistan has begun to take over the operation and maintenance of various average sized shrines. A few staff

members are employed to run the functions of the shrine. *Futuh* received is now used for the up keep of these shrines. Most of them are managed by the Auqaaf Department and governed by the Ministry of Religious Affairs. Thousands of people visit shrines every month making generous donations of food, money and clothing to the needy and deserving who live in the shrine, seeking healing for their physical and psychological ailments.

SUMMARY

Pakistan is a complex and patriarchal society with a turbulent history, experiencing much recent conflict. Very low levels of government spending on health and education mean that services are poorly developed and under-resourced and that access to health care is dependent upon families' ability to pay. Women have clearly defined and largely inflexible roles, principally in male dominated extended families, where domestic violence is common. Islam is overwhelmingly the majority religion and is interwoven into the everyday lives of the people. The historical legacy of Sufism and the shrines of long dead Sufi saints continue to provide an attraction to thousands of people in Pakistan in search of blessings and assistance in times of misfortune and ill-health.

CHAPTER 3: REVIEW OF THE LITERATURE

INTRODUCTION

This section sets out a review of the literature covering a broad range of areas pertinent to the topic under study.

I start with a brief outline of the scope of the review which tried to focus on literature from Pakistan and the Indian subcontinent but ranged far and wide to include studies from not only the Islamic world but many other developing and developed countries. Important issues concerning the relationship between culture, illness and sickness are explored and the literature relating to beliefs about supernatural possession and its ability to cause mental ill-health is examined. I then go on to look at studies pertaining to mental ill-health conducted in Pakistan and India, identifying levels of psychiatric morbidity and highlighting particular risk factors. The appropriateness of using a western psychiatric treatment model in a non-western cultural context and its level of cultural 'fit' is a clear theme emerging from the available literature. The research related to alternative healing resources that are used, including faith healers and religious venues is considered in more detail. This naturally leads on to studies exploring the role and function of religious pilgrimage and to a significant body of work looking at the effects of place on health and vice versa and the concept of 'therapeutic landscape'. Finally, the literature on factors affecting choice of healing resource, including stigma, completes this wide-ranging review.

SCOPE OF THE LITERATURE REVIEW

A variety of databases were used to conduct a comprehensive literature search on the research topic. These included Social Sciences Citation Index, Cumulative Index of Nursing and Allied Health, Medline (Pub med), PsychINFO, and Cochrane. The terms used for the search were 'shrine', 'Muslim shrine' 'healing', 'possession', 'magic', 'mental health', 'Islamic healing' and

‘faith healing’ as individual terms and in combination with Pakistan. Very few articles were found through this formal route, however, reference snowballing proved most useful in locating relevant research. As there was relatively little literature in the area of healing at shrines, the search was broadened to include key terms such as ‘mental illness, families, Pakistan’; ‘mental illness, stigma, Pakistan’; and ‘mental illness, beliefs, Pakistan’. The reference list from each article was reviewed and relevant articles consulted.

CULTURE, ILLNESS, AND SICKNESS

Illness perceptions and behaviour are shaped by local traditions and cultural orientation. Similarly, symptoms of any illness have cultural meanings attached to them. The cultural meanings reflect what is generally considered to be normal, abnormal, desirable, undesirable, and its associated causative theories (Kleinman, 1988).

In the literature, the concept of abnormality is described as “both peculiar and confused, because in it are contained two different notions; on the one hand, there is a judgment of value, of goodness or badness; on the other, there is a reference to the statistical average”(Yap, 2000 p. 181). This raises a question as to what behaviour can be considered as abnormal. Yap (2000) drawing on work from various anthropologists suggests that describing a person’s behaviour and making arbitrary reference to their cultural norm may help in understanding the perception people may attach to this behaviour and whether it is normal or abnormal. Some examples of cultural influences on definitions of health from a Western point of view include a preference for thinness over other body shapes and encouraging assertion of autonomy or freedom. On the other hand, in south Asian cultures, demands for personal space can be viewed as rejection as togetherness is highly valued and expected even if this means sacrificing one’s own needs and individuality. The use of physical violence to maintain discipline

in the family is also considered normal in many non-western cultures (Winkvist and Akhtar, 1997).

Kleinman (1988) refers to '*illness*' as a perception, lived experience and process of appraisal of symptoms and disability by the sick person, his/her family members or wider social networks. It involves the appraisal of a situation as expected and serious, and which may require treatment. He places crucial importance on the sick person's judgement of how illness can be coped with best, how problems of daily living can be overcome and what lifestyle changes need to be initiated or outside help consulted in order to deal with the problems being experienced. The perceptions attached to what is called, from a western perspective, 'ill' can have a very different meaning in different cultures and cultural interpretations of an illness and its course have a significant impact on how it is viewed. Illnesses like schizophrenia, when considered chronic, are assumed to inevitably change the person permanently, whereas in those cultures which relate psychosis to possession by evil spirits, the sufferer will be expected to recover once they have been relieved from the possession and remain unaffected in the long term (Good, 1997). Warner (1986) from his studies conducted in India, describes how high status and prestige is given to people with schizophrenia or in a state of psychosis.

Describing mental illness raises many questions in the context of culture. What is normal and generally invisible in one culture can be considered eccentric or odd in another. According to Dana (1993), what is perceived as abnormal is not a factor but a function affected by several factors, something that the observers' conscious mind is unable to integrate (cited by Javier et al., 1995). Definitions of mental illness have changed over centuries. For example, until recently homosexuality was a psychiatric diagnosis, defined in the Diagnostic and Statistical Manual (DSM). With changing values, it is now considered a norm, a different sexual orientation which has legal recognition and a legitimate place in society, in most Western countries at least. This kind of change is affected by

several factors within any society including, education, health beliefs and healing practices, the availability of health resources and attitudes (Yap, 2000). It is generally assumed that everyone prefers a state of health to illness. However, “uncritical acceptance of this assumption blinds us to some of the more important aspects of health behaviour” (Foster and Anderson, 1978 p. 148). Temporary illness is also associated with bringing special privileges and thus can be seen in terms of a coping mechanism, providing a socially sanctioned break from normal routines and the expectations of others. The authors go on to describe the role of illness in providing a release from unbearable pressure, gaining attention, exerting social pressure, and as a device to compensate for feelings of guilt.

The relevance of anthropology to psychiatry is frequently questioned. Although biomedical and genetic research in psychiatry has developed a strong position and gained credibility, it has consistently shown an association of some core disorders like depression, anxiety, and schizophrenia with a person’s social circumstances, personal relationships, and relationship with self (Good, 1997). The role of social and cultural factors in the recovery or improvement of illnesses such as schizophrenia has been highlighted in two major WHO studies where the prognosis for schizophrenia was considered much better in Nigeria and India than in North America and Europe (Sartorius et al., 1986). For Kleinman (1988), culture is of important relevance to psychiatry as it provides perspectives on what are fundamental questions in psychiatry. How to distinguish normal from abnormal, how disorder is perceived, experienced and expressed, and why treatment fails or succeeds. Kleinman (1980) describes medicine itself as a cultural system; a system of symbolic meanings anchored in a particular arrangement of social institutions and patterns of interpersonal interactions. In every culture, illness, the responses to it, ways that individuals experience and treat it, and the social institutions relating to it are all systematically interconnected. The totality of these interrelationships is the health care system.

Kleinman & Sung (1979) suggest that the function of a healing system is to: a) control the sickness: and b) provide meaning for the individual's experience of it. They go on to say that with modern health care's emphasis on a systematic approach, professionals are able to approach the first but are unable to take on board the second aspect. Gesler (1993) on the other hand describes the primary goal of any health care system as to "provide therapeutic landscapes or environments in which physical and mental healing can take place" (p. 171). He suggests that the health-care systems in many Western countries do not manage to provide 'therapeutic milieux' as the main focus is on cost containment to the detriment of nonmonetary factors.

It is clear from the literature that culture, illness and sickness are interrelated in complex ways. In psychiatric or mental health terms, this is even more so. Culture has a direct impact on expectations and approvals of behaviour and whether it is sufficiently abnormal to be labelled or experienced as illness or sickness.

PERCEPTIONS OF MENTAL HEALTH/ILLNESS AND ILLNESS

CAUSATION

Describing mental health and illness in a way that accurately reflects the context is very difficult. Unlike physical health, mental health is not usually understood as something one must strive for. Often it is not the presence of a particular symptom which suggests some pathology rather it is the absence of desirable behaviour that needs explanation.

In Pakistani culture, determinants of social control such as occupational functioning (Khan, 1979), respect for relationships and values, love and affection for family members and its appropriate display are important indicators of health. Absence of these often affirms the presence of pathology in an individual or family. This pathology is frequently associated with

supernatural phenomena, moral weakness, and/or biochemical imbalance and receives prompt attention from religious healers or health professionals (Karim et al., 2004). Behaviours such as outward displays of sexual desire, aggression, and talkativeness are considered to indicate the presence of a 'problem'. A Nigerian study also reported that these behaviours were considered signs of mental illness, however it is not clear if 'mental illness' was the researcher's own social construction or that of the people under study (Kabir et al., 2004).

Kakar (1982) explored healing principles and patterns in many traditional healing resources such as Ayurvedia, psychiatry, shrines and temples. Through his detailed conversations with healers and observations of patients and treatment, he concluded that the western view of mental health differs greatly from the ideals of mental health in the Indian subcontinent. Western psychiatry defines mental health in parallel with physical health and therefore the efficiency of brain systems to discharge chemicals to carry out daily activities is of high importance. In contrast, Indian healing systems, such as local and folk traditions, place high emphasis on the relational aspects of human living. The ability to maintain relationships within the family and society, and experiencing fulfilment and harmony is of prime importance. Modern psychiatry has its roots in Western Europe, Yap (2000) questions whether the principles and practices of western psychiatry can be considered to have universal validity and be applied broadly regardless of the target culture or society.

EXPLANATORY MODELS AND HELP SEEKING

An individual's EM determines the practical actions or series of actions that they may take when faced with a particular illness or problem. They are also considered to be cognitive maps, anchored in strong emotions and feelings. Kleinman suggests that investigating EMs from different sectors of any health care system may disclose the ways in which the socio-cultural context can affect

the relationship with the patient and interactions between the practitioner and health care system in general (Kleinman, 1980).

Five components can explain the EM of a practitioner or a patient; the aetiology of an illness; the time and mode of onset of symptoms; the pathophysiology; the course of the sickness; and treatment. In most cases a practitioner can readily provide answers for all the five components, however, it is the explanation of the patient that is important in order for the treatment goals to be reached.

Health beliefs are different from EM. Each individual has some health beliefs that may have been acquired from his/her immediate environment. It is a general understanding that exists in a person's life; though not necessarily part of their personal experience. EM's however, are the beliefs that arise in response to a particular episode of illness or sickness (Kleinman, 1980). Williams & Healy (2001) reporting from a large UK based survey found that people in general believed that minor mental health problems have a social basis rather than a biological. These results, however, contrasted strongly with the beliefs of those who actually suffered from depression. The sufferers considered biological alteration to be the main reason for their mental health problem and not social circumstances.

EMs can shed light upon the help-seeking processes used by the individual and the pathways they choose when faced with illness or problems. At times a person may have multiple explanatory models running simultaneously (Williams and Healy, 2001) or there may be incongruence or contradictions that exist within the model (Kleinman et al., 1978). Often, lay people, when presenting to a health service, keep their EM silent as they feel embarrassed and fear being ridiculed. Hahn (1995) suggests Kleinman's 'Explanatory models' (1980) and 'illness narratives' (1987) are similar to her 'accounts of sickness' (1995) and 'ideologies of sufferings' (1984) and also what Nitcher described as 'idioms of distress' (1982), and Brody's 'stories of sickness' (1987).

EMs can reveal multilayered and complex information regarding social rituals, symbols in communication, and knowledge and illness narratives (Bhui and Bhugra, 2002 p.). A very high level of dissatisfaction with treatment can result when there is a contrasting difference in the EM of illness between the patient and the practitioner (Callan and Littlewood, 1998). An approach by a practitioner which focuses on making a diagnosis and introducing treatment loses out on understanding of the patient's world and beliefs and the 'fit' of the prescribed treatment within these (Bhui and Bhugra, 2002). It is also important to consider that a person may present to a practitioner with a variety of explanations for the illness experienced. This is especially true at a time when people are trying to make sense of the problem, and in doing so may explore and move between a varied and complex set of beliefs. These can be considered not as EMs but as 'maps of possibilities', which either become firmer and stronger or are dismissed and replaced (Williams and Healy, 2001).

There have been some criticisms of the explanatory model approach. According to Dein (2003), "they fail to specify in any detail the extent to which individual explanatory models are shaped by culture and the extent to which they are idiosyncratic formulations" (p. 153). Garro (1986) criticises explanatory models for its focus on individuals beliefs and knowledge about an illness and its lack of consideration of the objective social order as a determinant of medical behaviour. Morsy (1990) makes similar criticisms (both cited in Dein, 2003). Pelto and Pelto (1997) suggest that people's decision making regarding help-seeking is inevitably influenced by economic, geographic, social and other constraints as well as facilitating factors, such as availability and access.

In the course of an episode of sickness, a person uses several kinds of knowledge, including theoretical and rationalised knowledge, and the knowledge acquired through the negotiation of "meaning of objects, events and experiences in interaction with other people" (Young, 1982, cited in Dein, 2003 p.153). Young suggests it is simplistic to assume that everything a person says

about a particular illness experience or event can be worked into a single coherent narrative.

Pelto and Pelto (1997) highlight that explanatory models are derived from general cultural beliefs about sickness and health care. “The EM is constructed, or assembled, by the participating individuals in order to deal with and make decisions about particular, individual illness episodes. Thus elements of the general belief system, such as interpretation of symptoms, are related to pragmatic elements (e.g. location and costs of various health services) at a more concrete level of conceptualisation”(p.153).

Dein (2003) however, cautions against reliance on people’s responses to typical interview questions as they may not reflect the action that people actually take. They may say one thing and do another. Pelto and Pelto (1997) suggest that health care behaviours and decision making is a complex process and cultural beliefs and explanatory models are among a number of factors that influence the process. Dein (2003) therefore, recommends looking at more “objective social factors and structures of inequality’ (p. 155) that may be preventing people from seeking alternate help resources rather than only subjective beliefs.

In Pakistan, symptoms caused by depression, anxiety or stresses are linked more with social adversity or disharmony in relationships, rather than ‘ill health’, and self-coping is prominent. These coping strategies may include crying, talking to others, praying, pleading for forgiveness from the Supreme Being, or visiting religious places (Hussain and Cochrane, 2003). Conversely, the range of behaviours shown by those with psychotic illness is received with much apprehension and confusion. These behaviours are frequently believed to be the result of supernatural forces such as spirit or jinn possession, black magic, testing by God, a curse, fate or as punishment for one’s sins (Gadit and Khalid, 2002 ; Gilani et al., 2005). Belief in supernatural forces as a cause of mental health problems is a widely recognised and socially accepted

phenomenon in many cultures. Only 1% of participants in a Nigerian study considered poverty, financial stress or social adversity to be causes of mental health problems (Kabir et al., 2004). While symptoms of anxiety and depression were not acknowledged as 'illness' and seen more as temporary problems, psychotic symptoms were given the name of 'madness' and sufferers avoided. The social exclusion associated with 'madness' can be severe and the stigma affects not only the individual but all those related to the person (Gadit and Khalid, 2002 ; Lauber and Rossler, 2007).

Kleinman (1988) when working with a Taiwanese group found beliefs and perceptions in traditional Chinese medicine that only hysteria and 'madness' were mental disorders; other problems (anxiety, depression and stress reactions) were considered physical problems or individual reactions resulting from life difficulties. There is a similarity in these findings with that found in the Pakistani literature (Karim et al., 2004). There is a general belief that the envy of others and the 'evil eye' can cause deterioration in general health as the individual is made vulnerable to harmful forces (Qidwai et al., 2002).

Similarities in explanatory models can be seen among all age groups and social, educational and professional backgrounds. A study by Srinivasan & Thara (2001) in Chennai, India found that 55% of relatives/carers of chronic schizophrenic patients believed that stress was the cause whereas 22% blamed it on a defect in personality, 15% on heredity and only 12% believed supernatural causes to be relevant. A clear limitation of this research was that it was a hospital based study and participants were caring for chronically mentally ill family members over a long period of time. As they sought help from a western model of psychiatry, it is likely that their worldview and belief systems favoured biological theories of causation of mental illness rather than supernatural ones. Also important is the idea that people may genuinely want to believe that psychiatric treatment will cure the illness.

In contrast to these findings, in their study conducted at different shrines in India, Padmavati et al (2005) reported that the main theme of illness causation among the mentally ill seeking healing there was possession and supernatural forces. Campion and Bhugra (1997) also found a strong belief in supernatural causes among patients with mental health problems and their relatives when the point of contact was with faith healers or at shrines. Possession by jinn is one of the causes assigned to people displaying significant changes in personality leading to a breaking of social norms such as being irresponsible in social and occupational functioning, openly displaying sexual needs, rebelling against the family and displaying behaviour that is likely to be a source of embarrassment to the family.

Very similar results were found in a study conducted at a university hospital in Karachi, Pakistan. A sample of over 400 people was given a vignette of a young person displaying schizophrenic behaviours. Participants were asked to attribute a reason for this behaviour and possible management of the situation. The sample was predominantly male and educated. Only 22% of them identified the situation as 'mental illness', whereas the rest assigned superstitious ideas (33%), God's will (32%), loneliness (24.8%), and unemployment as possible reasons. Only 40% considered psychiatric consultation to be the most appropriate management strategy, the rest identified spiritual treatment, social changes and doing nothing as ways of managing the situation (Zafar et al., 2008). Other studies have suggested that South Asian women acknowledge their physical and psychological symptoms and the life events causing them. However they relate them to the 'ups and downs' of living and take comfort in religious activities to cope with the distress rather than contacting doctors (Mastrogiani and Bhugra, 2003 ; Bhugra and Mastrogiani, 2004).

It appears that perceptions of mental health and illness vary from culture to culture and a clear east-west divide emerges. Definitions of mental ill-health in the eastern world relate to the failure to perform certain expected behaviours,

especially when connected to family relationships and the breaking of social taboos. Views on illness causation also vary. The western psychiatric model focuses largely on bio-medical causes of mental ill-health whilst folk or popular perceptions attribute causes to a broader range of sources commonly including social problems and the supernatural.

Several studies conducted in the Indian subcontinent have attempted to explore how 'mental health problems' were perceived, explained and experienced, and what kinds of help were sought. Some researchers refer explicitly to 'explanatory models' (Mirza et al., 2006), whilst others have focussed on perceptions or beliefs about 'mental health problems' (Sheikh and Furnham, 2000 ; Zafar et al., 2008). Further research has examined specific help seeking pathways chosen by those suffering from 'mental health problems' (Gadit, 1997 ; Saeed et al., 2000 ; Tabassum et al., 2000 ; Hussain et al., 2001 ; Farooqi, 2007). One way that these studies can help practitioners is by enhancing understanding of people's choice of help seeking pathway. Help-seeking is a complex process. It is influenced by explanatory models rooted in cultural beliefs, as well as social, economic and political factors. Research results may be affected by where (hospital, temple, or community) and by whom (professional background) the research is conducted.

PHENOMENON OF SUPERNATURAL POSSESSION

Possession is a recurrent theme in the literature and a number of authors have attempted to define or categorise it. Littlewood (2004) describes possession as the belief that an individual has been entered by an alien spirit or other para-human force, which then controls or alters that person's actions and identity. To the external world the person may appear to be in an altered state of consciousness and carry out actions that are out of the ordinary or show lack of adherence to cultural norms. Prins (1992) describes possession as an emotive word which implies an experience of being possessed by an evil force.

Involuntary possession refers to a situation where a person falls ill and later learns, through divination, that they are possessed, or the person may perceive a change in the self or behaviour and realise that it is due to the presence of a spirit. Involuntary possession involves possession by spirits from the local cosmology that are mischievous and malicious or by the spirits of deceased relatives although it is precisely these identities that appear to have become more anonymous over time (Halliburton, 2005). The definitions are largely consistent and the phenomena widely experienced.

POSSESSION IN THE LIGHT OF ISLAMIC TRADITION

Possession states exist in Islamic traditions as they do in many other religions (Sheikh, 2005). The alien spirit or force possessing an individual is often referred to in the Indian subcontinent as jinn³. The term 'jinn' comes from the Arabic word *jann* that signifies covered, covertness, protecting, shielding, veiling, and darkness - something hidden (Kakar, 1982 ; Dein et al., 2008). Jinn are knowledgeable and intelligent beings and are aware, more so than human beings and have the power to choose (Al-Ashqar, 1998). Most jinn are said to be malicious, destructive, and amoral beings. Islamic scholars mostly agree that jinn have the capacity to possess the human but there is disagreement over whether they can either influence or physically occupy space within a human being (Dein et al., 2008).

The existence of jinn is a fundamental tenet of Muslim belief. To understand the position of jinn and possession in Islam, it is important to refer to the Qur'an and the *Hadith* (sayings of the Prophet Muhammad PBUH). These have described jinn as real creatures, living alongside human beings and possessing great intellectual ability and power. Jinn can see human beings but not be seen

³ Jinn: (singular and plural), are spirits that reside in the ground as well as in graveyards. It is also perceived as a spirit; or a demon, who can both be an enemy or a friend or protector to the human being

by them. Their origin is different from human beings as they are made from fire, whereas humans are made from clay or mud. The Qur'an states "Verily We created man of potter's clay of dark mud altered. And the jinn did We create aforetime of a flameless fire" (Al-Hijr 26-27)(Al-Ashqar, 1998).

In spite of their power, it is said that jinn cannot automatically possess those who are true believers and can only overpower those who give in to worldly comforts and unreligious ways of living. According to Islamic belief, each person has a jinn and an angel accompanying them at all times, giving temptations for good and evil at the same time. It is the individual's way of living and choices that can determine whether they will be overpowered by the jinn and led to a sinful life. It is recorded in *Sahih Muslim* (one of the Sunni Six Major *Hadith* collections, collected by Imam Muslim, the second most famous *Hadith* collection among Muslims) and *Musnad Ahmad* (the collection of *Hadith* collected by the famous Sunni scholar Ibn Hanbal to whom the Hanbali madhab of Sunnis is attributed) that the Prophet (Peace be upon him) said, "There is none among you except that he has a partner entrusted to him from among the jinn." The companions asked, "You too, Oh Messenger of Allah?" he responded, "yes, but Allah aids me against him so I am safe from him and he only orders me to do good" (quoted in Al-Ashqar, 1998). Those who are strong in their faith and religious practices are believed to be able to achieve total control over their jinn and bring the jinn to accept Islam and be kind to humankind. For example, the Prophet Solomon had many jinn under his control and they worked for him. This example is often used to affirm such beliefs. Ibn Taimiya (Islamic scholar) explains that jinn can have lustful desires and passions for a human being or they can have feelings of hate resulting from the perception that the human is trying to harm them. Both these situations can lead to possession (Al-Ashqar, 1998). Kakar (1982), reported the perceptions and beliefs among healers at several temples that after death, the body should be either buried or burned in order to completely destroy the jinn, however, some jinn, especially those of a

sinful man escape the human body through elimination and then lurk around dark, dirty, or deserted places, waiting to attack their victim.

From an Islamic viewpoint once a person is possessed, the jinn has the ultimate power to cause suffering. The possessed individual starts talking in incomprehensible language, shows indifference to physical pain or discomfort, or displays excessive strength or changes in their usual behaviour. In addition, the person can suffer from a variety of ailments including lack of sleep, nightmares, anxiety and depression (Al-Ashqar, 1998). In his review of various case studies from several countries, Prins (1992) summarises the symptoms that are manifested by those who could be considered truly possessed. These include fits, fainting, contortion of the limbs, unusual strength, voice changes, violent dancing, a claim to have clairvoyant powers, insensitivity to pain, vomiting, nausea, paralysis in varying degrees, utterance of obscenities and blasphemies, an understanding of unlearned languages and a capacity to speak them, and fear of the Divine presence and ritual and regalia associated with it. Most of these are supported by Al-Ashqar (1998) in his description of possession. It is because of these symptoms that people are taken to faith healers and treatment is carried out using a variety of methods including recitation of Qur'anic verses and physical beating (Khalifa and Hardie, 2005).

POSSESSION IN DIFFERENT CULTURES

It is evident from the literature that worldviews of different cultural/religious groups and psychiatric observations overlap but also remain distinct. Belief in possession is apparent in many cultures.

Possession states have been considered by some as culture bound syndromes widely existing and accepted by native communities. Some examples include the condition 'possession by *bhuta* (ghost)' (Nichter, 1981 ; Freed and Freed, 1990); 'possession syndrome' (Kapur, 1975 ; Yap, 2000) in India and Siberia, and 'Grisi Siknis' in Nicaragua and Honduras. In this state, young females are said to

perform remarkable acts while being in a trance-like condition (Prins, 1992). Similarly, 'Zar possession' in Egypt, Sudan and Ethiopia (Constantinides, 1985); 'Voodoo and allied states'; in Haiti and among the Mayotte (Lambek, 1989) where useful spirits are given the status of either social kin or evil spirits requiring exorcism. Nitcher (1981) suggests that among Havik women in India, preoccupation with the 'evil eye' and/or possession can be considered both the 'idiom of distress' and a coping strategy. In the study those most vulnerable to this experience were reported to be in transitional states or stages of development such as pregnant women, babies, and those achieving new success.

Researchers have made an attempt to explore whether beliefs around possession change with modernisation in a specific culture. A study by Halliburton (2005), explored the experiences of people in Kerala, India seeking healing for psychological problems and possession at three healing centres i.e. allopathic psychiatry, Ayurvedic psychiatry, and a religious shrine. He suggests that modernisation had eroded the traditional cultural context in Kerala resulting in a change in the way people described their ailments. Compared with previous findings, people less often reported themselves to be possessed and those who thought they were possessed reported their spirits to be more anonymous or free floating. He also found that feelings of tension and stress, the idiom of distress of the modern world were commonly used by those who perceived themselves possessed.

Marwick (1965) argues that belief in sorcery provides "a means by which tense relationships may be formulated and sometime redressed" (p. 283). Jones (1970) states that supernatural beliefs are used "to manipulate situations in which roles are competitive and ambiguously defined" (pg. 327). In developing a possession state, the role of the individuals' suggestibility or disclaiming their responsibility for an inappropriate or unacceptable behaviour is suggested by some (Prins, 1992).

Some researchers suggest that trance states can also be achieved voluntarily. This includes entering into a self-induced trance, allowing the spirit of a saint to enter the body in order to fight the evil already possessing them (Henry, 1977 ; Pfleiderer, 1988 ; Freed and Freed, 1990). In this way, possession serves as a cause of illness as well as the main treatment.

Although belief in possession is clearly widespread, there is a suggestion that beliefs diminish as a society modernises and takes on different or western idioms of distress (Halliburton, 2005).

JINN POSSESSION IN THE LIGHT OF PSYCHIATRY

While possession is a common experience in many cultures, in Western cultures, such experiences are not considered normal or acceptable and this may lead to psychiatric diagnoses, mostly dissociative or psychotic disorders which may be inappropriate (Prins, 1992). ICD 10 and DSM classification, both cover possession and possession trance under the diagnosis Dissociative Disorder Not Otherwise Specified (Alexander et al., 1997), however its use in clinical practice in India remains limited due to its lack of explicitness and clarity (Das and Saxena, 1991).

Prins (1992) presents a distinction between the truly possessed individual and the mentally ill. According to him, the possessed retain their sanity most of the time in spite of being very restless and do not talk about their demons and evil spirits unless asked about it directly. Whereas the mentally ill may talk about their demons and are significantly distressed by the blasphemous thoughts they may experience. This is not the case with the genuinely possessed. In addition, possession is seen as more of a transient experience whereas schizophrenia may affect the person on a long term basis.

The phenomenon of possession has interested health professionals from a variety of disciplines. Kakar (1982) describes the concept of the jinn in parallel

to one's unconscious – and suggests it is based on the id impulse, and is self-centred. Chandershaker (1989), presents his theories concerning possession in the light of three theoretical frameworks, that is, dissociation theory where the id overwhelms the ego and dissociates the person from a state of reality; communication theory, where a repressed or oppressed individual assumes the sick role in an attempt to gain gratification and attention; and socio-cultural theory where a person is exposed to culturally sanctioned phenomena such as jinn possession and the individual expects that they may suffer from it if their ways of living are not in line with sanctioned limits and boundaries (Khalifa and Hardie, 2005).

Literature from both Islamic and psychiatric sources on the topic of possession shows how the manifestations are very similar but explanations are different. In Islamic literature, possession is described as a widely held belief which can be interpreted in the light of the Holy Scripture, whereas in western literature it is a little understood and/or accepted concept and often labelled by psychiatrists as psychosis, hysteria or schizophrenia. It is not only interesting to note the presence of jinn within Islamic religious texts but also the absence of any direct link being made between jinn and mental illness. Dein et al. (2008) point out that belief about the links between spirit possession and mental illness exist not only in Islam but also in Hinduism, Buddhism and Judaism.

In the academic literature, several published studies have highlighted jinn/evil possession as one of the most common explanations of 'mental health problems' among those attending psychiatric services or other healing places (discussed in the earlier section - Explanatory models and help seeking).

The dilemma for health professionals is deciding which lens they should be using when encountering the phenomenon of possession. Possession when viewed from a western psychiatric perspective can easily be categorised as a

recognised disorder and Prins's (1992) distinction between true possession and mental illness may be very difficult to recognise or accept in practice.

MENTAL HEALTH STUDIES IN THE INDIAN SUBCONTINENT – PSYCHIATRIC MORBIDITY IN THE COMMUNITY

Moving on to look at mental health more broadly, there are a number of epidemiological studies concerning the prevalence of anxiety and depression in the Indian subcontinent that have been performed over many decades (references provided below). More recent research has integrated questions around the usefulness of a western model of psychiatric treatment approaches in the Indian subcontinent compared with native/traditional cultural healing practices.

Studies carried out in Pakistan estimate prevalence rates for common mental disorders (CMD) i.e. depression and anxiety, to be very high. A systematic review of epidemiological studies for anxiety and depression (Mirza and Jenkins, 2004) found a total of 20 studies. These included various community surveys estimating prevalence (17) and associated risk factors (11) for CMD in community samples from rural Punjab and Sindh. Sample sizes ranged from 113 to 2620 in the prevalence studies. The overall mean score for men and women was 33.62% (n=2658) with the point prevalence ranging from 28.8% to 66% for women (overall 45.5%) and 10% to 33% for men (overall 21.7%). A recent community survey conducted in the tribal areas of Pakistan found that 66% of women and 45% of men met the criteria of depression and 60% of the total sample expressed suicidal ideas. Considering that the people in these tribal areas of the North West Frontier of Pakistan are relatively isolated from the rest of Pakistan, are predominantly poor, and have poor access to health education and basic living facilities, the findings do not come as a great surprise (Husain et al., 2007). Interestingly, when comparing the results from these various

prevalence studies conducted in Pakistan, a higher prevalence is noted in rural populations compared to urban.

The screening tools used in prevalence studies include Bradford Somatic Inventory (BSI), Hospital Anxiety and Depression Scale (HADS), General Health Questionnaire (versions GHQ12 and GHQ28), Self-Rating Questionnaire (SRQ), the Pakistan Anxiety and Depression Questionnaire, Life Events and Difficulties Schedule (LEDS), Aga Khan University Anxiety and Depression Scale (AKUADS) and psychiatric interviews using ICD-10 Diagnostic Criteria for Research, and the Psychiatric Assessment Schedule (PAS) (Mumford et al., 1996 ; Chisholm et al., 2000 ; Husain et al., 2000 ; Mumford et al., 2000 ; Karim et al., 2004). A number of hypotheses and theories regarding the conceptualisation of mental health problems, issues around linguistic and contextual translations of the research tools used, and the cultural context of the research process have been illuminated and opened up other avenues for further research (Rahman et al., 2003). As a result some determinants have been identified as risk factors for developing mental health problems.

RISK FACTORS FOR MENTAL HEALTH PROBLEMS

A systematic review of the literature highlights that higher prevalence of CMD in Pakistan is significantly related with poverty and low literacy levels and to some degree with other vulnerability factors such as lack of a confidant and having three or more children (for women) (Patel and Kleinman, 2003). These are not entirely dissimilar to risk factors in the western world (Husain et al., 2004). Lower prevalence of psychiatric morbidity is related to higher literacy, although it has been hypothesised that more literate individuals might have increased chances of migrating to urban centres and achieving a higher standard of living (Mumford et al., 2000). Living in conditions where social change is taking place is also associated with increased mental health problems as the individual deals with high expectations from self while facing ever-changing circumstances.

Vulnerability, insecurity, and hopelessness are significant negative factors associated with higher risk (Patel and Kleinman, 2003).

Being a female poses an even greater risk for developing psychiatric morbidity, including deliberate self harm (Mumford et al., 1997 ; Ali and Amanullah, 2000 ; Husain et al., 2000 ; Mumford et al., 2000 ; Khan, 2002 ; Mirza and Jenkins, 2004 ; Zakiullah et al., 2008). Women living in extended families, are at greater risk and factors perceived by women to be related with anxiety, depression, and deliberate self harm and suicide attempts include abusive relationships and conflicts with the husband or in-laws, and financial difficulties (Khan et al., 2008). Women are encouraged to be subservient and domestic violence and abuse, and conflict with spouse and in-laws, are common (Niaz, 2001). Niaz (2003) suggests that up to 90% of the female population in Pakistan experience domestic violence. It is suggested that women accept violence and abuse as normal behaviour and believe that if they make adjustments in their expectations, then stability can be gained and maintained (Rabbani et al., 2008). Long term abuse by their husbands can make women indifferent and they make minimum efforts to protect themselves. Constant humiliation, physical and sexual abuse, control, isolation and insecurity gives a rise to psychological conflicts and also leads to self harm and suicidal attempts (Khan, 2002 ; Zakiullah et al., 2008). On the other hand, supportive relationships within the family have been noted to act as protective factors against the development of anxiety and depression (Mirza and Jenkins, 2004 ; Zakiullah et al., 2008).

A study exploring the impact of the social environment and social conditions on the mental health of pregnant women in Pakistan found that poor social relations was the most important factor associated with high CES-D scores (determining depression) (Kazi et al., 2006). Sonuga-Barke et al (1998) noted that the strong hierarchical structure in Asian families, the power differences between men and women, and the power of in-laws enforces the subordination

of married women, making them feel trapped and as a consequence increasing their vulnerability to mental health problems. Niaz (2003) reports several studies from Pakistan, where the representation of women among patients using mental health services was higher than men. During consultation, it was also found that a significant proportion of these women were educated, married, between the ages of 20-45 and had children. Their level of distress was thought to be related to their family situation rather than the presence of a mental health problem.

Gilbert et al (2004) explored issues of shame, *izzat*⁴, subordination and entrapment among south Asian women living in the UK and its impact on their mental health. They suggest that subordination is closely linked to *izzat* and in particular being the vehicle for family honour and obeying cultural rules. “The fear of bringing shame to others was linked to socially defined rules and prescriptions for reputation gaining and maintaining, via culturally transmitted systems of honour (*izzat*). To lose honour or to bring dishonour is to be externally shamed, lose status in the eyes of others’ or even disowned by the family and community” (p. 126).

Interestingly, Lindisfarne (1998) emphasises that values such as shame and honour are not only socially defined but importantly, defined by those in power. She elaborates that in many cultures, male honour and shame is perceived to be related to the control of women’s sexuality. Therefore males can lose honour and be shamed if they fail to control women in their network. It is this position of social power, held by men, parents, or in-laws, that gives them license to exert social control, and empowers and encourages them to positively endorse these values. These ideas have also been affirmed by Weiss (1985).

⁴ Izzat - reflected shame and honour (the shame and honour that can be brought to others by one’s own behaviour)

Many previous studies have highlighted a high prevalence of CMD in Pakistan although the relevance and appropriateness of the screening tools used in the research can be questioned. Those studies estimating higher rates of anxiety and depression among rural populations in Pakistan identify unemployment, poverty and lower levels of education as clear risk factors. For women, the risks are even greater with very high rates of domestic violence and high expectations being placed on women in terms of their responsibility for family honour and the need to conform to social and cultural roles.

WESTERN PSYCHIATRIC MODEL IN THE SOUTH ASIAN CONTEXT

Health professionals “interpret the health problem within a particular nomenclature and taxonomy, a disease nosology that creates a new diagnostic entity, an ‘it’ – the disease” (Kleinman, 1988, p. 5). How health professionals define sickness and how it relates with the subjective experience of the patient therefore raises an interesting debate. Considering sickness a common or global phenomenon that is experienced by any individual regardless of their cultural and social background may be a naïve approach (Hahn, 1995). Health professionals, who place an emphasis on objective measures of reality in terms of biochemical imbalances and use a narrow spectrum of categorising and diagnosing illness, are said to be negating meaning and the experience of the distressed (Kleinman, 1988).

Cultural pluralism exists within the boundaries of every country. Westerners’ attitudes toward health care are largely Eurocentric and generally consider that only their cultural traits are valid and worth possessing. Western society, entrenched as it is within the biomedical system (physician, medications, labs, machines) considers those countries with underdeveloped medical systems to be inadequate, while completely negating the existence of non-medical health care systems (Meade et al., 1988). Summerfield (2004) asks whether western

notions of suffering can really be seen in global terms, divorced from culture. Disregard for the socio-culturally determined understandings that people bring to their active appraisal of the situation they are in and on their expressions of distress and help-seeking, is questioned. Summerfield identifies the patronising attitude of western psychiatry and assertion of knowing the 'real problem' as problematic.

Psychiatric training based on a predominantly western psychiatric model has led to an increase in the use of mental health screening tools and classification indexes in the developing countries (Acharyya, 1992), including Pakistan. It is important to remember that, in Pakistan, although the training and prescription patterns of doctors are according to western psychiatric models, not all facilities can be taken for granted. For example, community care for patients after discharge, the availability of welfare benefits and a social welfare system and the possibility of accommodation for the homeless do not exist. This lack is compensated for by the presence of the family (Deva, 2002).

In Pakistan, when patients are diagnosed with 'mental illness' by a clinician they are often treated in a hospital setting or clinic using predominantly biochemical treatments. Primary care services are mostly clinic based and referral is from rural health centre to district hospital. The services offered at either venue are very limited. Specialist care is often based in private hospitals and is very expensive. Diagnostic interventions such as psychometric testing, EEG, and brain scan and treatments such as psychotherapy, individual/family/couple therapy, and ECT are available but often prohibitively expensive (Karim et al., 2004).

Many of those people who identify their own or their family member's distress as an illness and seek medical help, experience a high level of dissatisfaction. Minimal or poor quality training among mental health professionals or GPs often leads to over or under prescription of psychiatric drugs causing significant

delays in therapeutic effects and/or side effects (Gadit and Khalid, 2002). At times, the prescription of specific drugs to treat mental illness is driven by the influence of pharmaceutical companies rather than the appropriateness of treatment (Khan, 2006). Cost implications for patients, lack of information/knowledge about how the drug will help, and side-effects were the top three reasons that led to discontinuation of antipsychotic medications among a sample of patients from Pakistan (Rana and Ayub, 2002). These findings were echoed by Kapur (1975) in his study where psychiatric practitioners were shown to have had poor training in psychiatry and dispensed minor and major tranquilisers generously, based on the information given to them by drug companies. With a clear lack of expertise and relevant qualifications among those prescribing psychiatric medications and the influence of pharmaceutical companies, it is not surprising that prescribing is often erratic and futile. Overall, prescribing trends are strongly influenced by socio-economic factors, the availability of drugs, safety and cost factors (Gadit, 2003).

As the cost of medical treatment is largely borne by the family, this is an additional source of stress and often results in an early discontinuation of treatment and a level of dissatisfaction which affects future choices around health management and consultations (Rees, 2003). Considering that one third of the population in Pakistan live below the poverty line and the country has reportedly high rates for psychiatric morbidity, Khan (2006) raises an interesting question concerning the point at which an understandable response to distressing life events becomes an indication for drug treatment?

There is a little data available about the utilization of mental health services in Pakistan and outcomes in terms of effectiveness. Mirza & Jenkins (2004) conducted a thorough systematic review of the literature and found no study addressing the effectiveness of treatment or the prevention of anxiety and depression.

Patel (2000) points out that it is naïve to assume that the treatment measures, either biomedical or psychological, offered in western or developed countries can prove to be equally efficient when offered in developing countries. The acceptance of biomedical interventions for mental health problems is significantly influenced by how the cause of the distress is perceived and explained in Asian cultures. In addition, the emotional vocabulary used and idioms of distress are not same as in western cultures. However, psychiatric professionals are tested and qualified based on their ability to use and apply western idioms of distress to a culturally different group and how knowledgeable they are of western based literature (Jadhav, 1996). In addition, while individuation is often a prime focus in many forms of talking therapies in the West, important values that are idealised in Asian cultures include togetherness and joint decision-making (Hahn, 1995). Using an individual approach to therapy in an Asian culture may then conflict with these values. This area warrants further investigation if services offered are to be relevant and acceptable and is explored a little further in the next section.

Differing cultural definitions of health and sickness, a medical education system based on western psychiatric models, poor quality of psychiatric training and prescribing practices, combined with differing idioms of distress and the financial cost of treatment, challenge the 'fit' of a western psychiatric model in a Pakistani socio-cultural system and make it a less attractive source of help for mental distress.

PAKISTAN AS A PATRIARCHAL AND COLLECTIVIST SOCIETY

Collectivist cultures emphasise the interdependence of every human and groups (family or community). Individualist cultures emphasise that people are independent of their group. Triandis (2001) describes four important attributes when examining cultural constructs: the definition of the self as independent or interdependent; the primacy of personal or in-group goals; the primary

emphasis on attitudes or norms as the determinants of social behaviour; and the importance of exchange or communal relationships. In addition, each individualist or collectivist culture can have some unique attributes which may distinguish it from other cultures. Horizontal cultures emphasise equality and vertical cultures emphasise hierarchy. In this way horizontal individualism is characterised by an emphasis on all people being equal but each person is also unique; vertical individualism reflects both being distinct and the best in relation to others as well as different from others. Horizontal collectivism is characterised by merging the self into the in-group, but there is no suggestion that members of the group are different from each other in status. Vertical collectivism on the other hand, accepts hierarchy within the in-group. Thus, some have greater authority and more status than ordinary in-group members. Vertical collectivism especially emphasises the sacrifice of the individual for the preservation of the in-group (Triandis, 2001). Using Triandis's framework, Pakistan would be characterised as a vertical collectivist culture. With its prevailing patriarchal culture, it is women who are most likely to sacrifice their health, survival chances and life options for the sake of the family group (Moghadam, 1992).

Kakar (1982) suggests that while in the west, approaches to mental health issues revolve around the individual as the central focus, in the Indian context, the emphasis is placed on relational aspects, in particular between the individual and their family and community. Therefore a restoration of the lost harmony between the person and his relations is considered to be the key to recovery. From the view point of collectivist cultures it is suggested that people are more likely to favour harmony over autonomy and attempt to resolve conflict within a group by obliging, avoiding, integrating, or compromising behaviour which is different from those living in individualistic cultures like the USA (Yamaguchi, 2001).

In a country like Pakistan, patriarchal forms of control are maintained over women through the issuing of restrictive codes of behaviour, the practice of strict gender segregation, and the promotion of specific forms of family and kinship and powerful ideology linking family honour to female virtue. Men in these settings become protectors of family honour by controlling female members of the family (Moghadam, 1992). These societal systems largely exclude women from making decisions, give them limited access to and control over resources, restrict mobility and rarely encourage women to use assertion or autonomy to influence change in their situation (Fikree and Pasha, 2004). 'Proxy control' is a term used by Yamaguchi (2001) meaning control by someone else for the benefit of the person to describe third party intervention or intermediaries who regulate interpersonal relationships between parties. The author considers 'proxy control' to be essential for the survival of those who are in a weaker position thus lacking the skills, resources or power necessary to change their environment or situation. In a Pakistani context, this may include those women who experience oppression and abuse and find themselves in a situation where they cannot see any way out.

By examining Pakistani society in terms of patriarchy and collectivism, it is clear that the social order and structure is very much at odds with western notions and systems of psychiatric care and treatment. This again leads to questions regarding the 'fit' of a western psychiatric model in a place where society is vertically collectivist and patriarchal and the welfare of the individual is considered less important than the whole group.

RELIGIOUS HEALING RESOURCES IN THE INDIAN SUBCONTINENT

Traditional healers and supernatural, religious, and magical approaches to illness play a significant role in help-seeking and the treatment of people who have mental illness (Gadit, 1997 ; Saeed et al., 2000 ; Tabassum et al., 2000 ;

Lauber and Rossler, 2007). In the Indian subcontinent, people commonly use a range of alternative healing resources including faith healers and religious venues such as shrines and temples. The literature in this area focuses on the extent of their use and their healing frameworks.

FAITH HEALERS

Pir, Fakir or *Baaba* in Pakistan, India and Afghanistan, Saadhu in India, Fekki and Sheikh in Sudan and other Arab countries and Mutawee and Mullah in United Arab Emirates, all these are commonly known for their religious healing abilities and practices. They enjoy their position and prestige as community resources and in being able to intervene at times of despair and distress (Baasher, 1982). Those who are truly dedicated to the cause will offer these services without any reward; however they will accept gratitude and donations given by followers. Similar resources have been described in other cultures and countries. Examples include 'Mapuche Machi' (Shaman Healer) in Latin America (Felton, 1975), and the 'Bomoh' in Malaysia (Razali and Najib, 2000).

In Pakistan, the faith healer, commonly known as *aalim* or a *Pir* plays a crucial role in providing healing to people suffering from a variety of mental ailments and is often the first point of contact when an individual or family experiences mental distress (Mubbashar and Saeed, 2002). The *Pir* claims to possess the power to communicate with God through the world of spirits (Gadit, 1997). Faith healers reportedly prescribe a variety of treatments such as amulets containing Qur'anic verses, holy water, special prayers and/or the slaughtering of animals to deal with the problem (Winkvist and Akhtar, 1997). A study in New Delhi, India examining pathways followed by patients with mental health problems before coming to a psychiatric facility revealed that of 200 patients interviewed, 57% attended mental hospital as the first choice and 30% accessed faith healers. Interestingly, more men than women presented initially to psychiatrists. The option of using a religious venue for healing was however not available in the questionnaire used (Chadda et al., 2001).

It is suggested that the preference for faith healing may be a result of the healers' ability to connect with people, the language they use, their reputation for being trustworthy, and their ability to focus on treating 'illness' rather than sickness (Henry, 1977 ; Kleinman, 1980 ; Chadda et al., 2001). It is also suggested that they are well used not only because of the unavailability of western model psychiatric services but because of the faith healing model's 'fit' with the explanatory models of people experiencing mental distress. WHO studies of pathways to care have found that native faith healers play an important role in caring for clients with emotional difficulties (Sartorius et al., 1986). These faith healers are not only approached when health care is not available, but are also considered better in dealing with emotional difficulties than western style medicine (Gater et al., 1991).

Many faith healers claim that they provide holistic care which is accessible and available to all sections of the community. The understanding of holistic care in western psychiatry is likely to include bio-psychosocial aspects of care, whereas faith or other healers utilise herbs and/or a nutritious diet in their approach to healing (Saeed et al., 2000). Some healers however do substitute herbs with psychiatric medications in their healing process causing serious side effects and complications (personal experience). The term 'holistic' may not be equivalent in the practice of different healing models. There is, therefore, a need to explore in detail the actual practice of faith healers and their claim to be holistic, if it is to be integrated in clinical practice.

HEALING PLACES

The importance of religious venues as places of healing is apparent in all the worlds' religions. Places of religious worship for Muslim, Hindu, or Christian, all serve as mental health resources for the general community in the Indian subcontinent. Many of these places including '*dharamshaalas*' (religious convents), temples and shrines play a significant role in offering non-medical treatment options aimed at enhancing overall well-being. As previously

mentioned, shrines are places where Sufi saints are buried and are sacred to the followers of Sufism. These religious places are centres for religious education and resources for physical, mental, and spiritual well-being for people in various Muslim cultures. The sacredness of shrines and the healing powers of saints are beliefs that each child in Pakistan is exposed to from an early age. Religion is taught in every school, whether religious or secular, as a compulsory subject and visits to shrines and paying respects to saints are routine for most families in Pakistan. The healing rituals offered at shrines are sometimes compared to psychotherapy due to their impact on a person's psychological health (Pfleiderer, 1988).

Tyson (1997) in his work in Turkmenistan observed the clear role that a shrine plays and the rules that are followed by people making a pilgrimage to the shrine in order to seek healing. People with mental problems were expected to sit in one corner of the room and wait for a miracle, to be performed by the powerful saint (Khoja Yusup Baba), whereas those with sick children left behind an article belonging to the child in the shrine so that the ailment remained with the object and freed the child from illness.

El-Islam (1967) observed the ritual of 'sheikh visiting' in Arab countries. His findings focused on a psychodynamic view and he noted that people's psychological need to submit to a parent figure was an important factor in bringing about a positive outcome for visitors. However, what was not discussed was the role of faith and belief in bringing change or the process of joining in community rituals and its impact on physical and emotional well-being. Similarly, possession cults in India provided non-Brahmin women avenues for expressing emotions and brought to light conflicts within their relationships. The manipulation of social roles and receiving support from other women contributed to positive outcomes (Nichter, 1981).

Every year, about 10% of the 5 million people who visit 'Lourdes', a small town situated in the French Pyrenees, do so for healing purposes. According to Catholic teaching the Virgin Mary appeared in a series of visions to a 14-year old girl and indicated healing possibilities through carrying out religious rituals and immersion in spring water. People suffering from various physical and emotional illnesses including disabled children and the chronically ill are taken there in the belief that healing may be achieved and suffering eased through this pilgrimage (Rees, 2003).

STUDIES OF MENTAL HEALING PERFORMED BY FAITH HEALERS

Many previous studies have examined problems presented to faith healers from a western psychiatric perspective and categorised them using the DSM or ICD system of classification (Malik and Bokharey, 2001 ; Raguram et al., 2002). A comparison of diagnoses between faith healers and psychiatrists of a sample of people consulting faith healers in rural Pakistan (Saeed et al., 2000) showed little agreement between the faith healers classification and the DSM III diagnoses of the psychiatrists. While the faith healer diagnosed the problems as *Saya* (influence of evil spirits), and Jinn possession, the DSM diagnoses were of major depression and anxiety disorders. The common treatment offered by the faith healers included exorcism or removal of the possession, prescribing religious amulets, conducting of religious ceremonies, and giving advice around adherence to regular prayers.

The prevalence of mental health problems among attendees at five faith healers in rural Punjab was explored by Saeed et al (2000). Over 60% of attendees were given a research diagnosis of a mental health problem. The majority of these problems were major depressive episodes, anxiety disorders, epilepsy, and psychosis. Women were found to be over-represented in cases of depression and anxiety whereas men mainly presented with psychosis. The faith healer's system of diagnosis and treatment focused on the cause of illness in the context of the client and not the symptoms. They claimed to be using a holistic approach,

bringing together physical, psychological, and social methods to promote healing. There was a strong involvement of family and other community resources in the healing process, which kept the client in close touch with his/her social context (Saeed et al., 2000). As a result, the healers achieved a greater level of satisfaction and approval from their clients and families.

Campion and Bhugra (1997) conducted a study in Tamil Nadu, India exploring the prevalence of those who used faith healers to deal with 'psychiatric illnesses'. Findings from a sample of 189 patients attending a psychiatric care facility suggested that 84% of the patients, representing all major religions, consulted religious healers prior to contacting psychiatric services. The proportion of those seeing faith healers was higher amongst those from lower socio-economic groups, who had only a primary level education. The practice of contacting faith healers was also more common among Muslims than Hindus or Christians. 48% of the patients who identified the cause of their illness as psychological or psychiatric still went to the faith healers. This percentage rose to 71% for those who considered themselves possessed. The geographical distance from psychiatric facilities had no influence on the decision to use either resource. The study did not explore whether any of the families had actually sought medical treatment before contacting faith healers or why they chose faith healing in the first place. Studies like these have attempted to estimate the population who have dropped out from religious healing or used it in parallel with western psychiatry. However, people who only used religious healing and recovered and/or were re-integrated into the community largely remain unnoticed by researchers.

Farooq (2007) conducted a study in Lahore, Pakistan exploring the use of traditional healing among psychiatric patients attending a psychiatric outpatient department. All of her (78) participants had previously sought treatment from traditional healers including homeopathy, *tibb* (herbalist), sorcerers, and religious healers. Women outnumbered men in terms of

consultations sought and were more likely to utilise faith healers than men, who in turn used homeopaths more often. The author relates this difference to greater economic independence and mobility among men which enables them to spend more money than their female counterparts. It was suggested that women are more restricted in seeking help for their ailments from professional healers, who may be more expensive. They therefore rely more on traditional sources of help which they perceive to be more affordable.

Faith healers frameworks for healing

Kleinman (1988) describes a four stage model of how symbolic healing works, based on the work of several anthropologists (Douglas 1970, Dow 1986, Glick 1967, Horton 1967, Janzen 1978, Kleinman and Song 1979, Messing 1968, Moerman 1979, Nash 1967, Tambiah 1968, Turner 1967, Wallace 1959, and Young 1977). Stage I explains the presence of the *symbolic bridge* between personal experiences, social relations and cultural meaning. The presence of an ailment is seen in a cultural light influenced by social relationships. Stage II begins when this symbolic connection is activated. The person seeks out a healer who reassures them that the problem can be redefined. Both the healer and the one seeking healing share a similar world of social meaning and causative theories. A reciprocal relationship between the client and healer begins. The healer, using various methods, tries to redefine the problem while validating the meaning of the problem the client has attached to it. The client in return actively participates in the therapeutic regime and commits to it. This engagement process changes the way the problem was initially viewed by the client and slowly reshapes it to fit the healing system. For example, repeated crises may be assigned the diagnosis of evil eye, or unexplained anger outbursts may be seen as possession. In stage III, the healer works on bringing therapeutic changes to the client's emotional reactions. From a general idea about what the problem might be, the healer moves on to more specific problems which come to light as the relationship and trust between the healer and client develops. In stage IV

the healer confirms the transformation in the client using symbolic cultural meanings.

Kakar (1982) made a detailed observation of various traditional healers in religious settings and their framework for diagnosis and treatment. Through the stories shared by the healers and those seeking treatment, he found similarities between the descriptions of supernatural forces and unacceptable and forbidden desires and thoughts which individuals carry around. According to him the therapeutic elements of the cure that take place in the healing temple offer similar functions to a psychotherapeutic relationship with a therapist. He discusses the significance of the following: 1) the person is assured that s/he will be cared for and his/her needs will be satisfied (social or spiritual); 2) the person is able to face the factors causing them distress (ghosts/jinn) which the person gradually becomes familiar with and less frightened of; and 3) a catharsis – that takes place in the dissociative state of '*Peshi*' where unacceptable roles and impulses are acted out; 4) employment of defence mechanisms like denial, projection, and suppression and repression of conflicts, with the help of onlookers; and finally 5) bringing up stressors/conflicts within the family and mobilising a realignment of strained relationships.

'*Mantrawadis*' and '*Patris*' are types of traditional healers in India who work on the principle that illness is caused by past misdeeds committed by either the sufferer or their family in their present or previous lives. The suffering is brought on by the God of destruction altering the sequence of the stars or the personality of the acting demon (Kapur, 1975). The treatment subsequently focuses on zodiac manipulation and mystical verses recited over a talisman worn by the sufferer. It is also suggested to sufferers that they carry out some tasks to perform penance. A '*Patri*' has the ability to act as a medium for the spirit or demon and intervenes with the possessing demon. The beating of a drum and burning of incense often facilitate the trance-like state in which the dialogue between the spirits/demons and the sufferer takes place. Halliburton

(2005) describes a similar process for exorcising evil in what is called '*Puja*' in the Chottanikkara temple in India. The person engaging in this particular treatment, however, did not necessarily describe themselves as possessed. People entering the state of *Puja* manifested swaying of the body and the head, thrashing around on the ground, and muttered nonsensically.

The literature describes a variety of frameworks used by healers and authors have often sought to explain them in terms of notions of therapeutic processes and the interaction between healer and patient. There is an absence of any exploration of this healing experience from the point of view of the patient/attende.

Abuse in faith healing

Illiteracy, distress, poverty and lack of information about and access to health services all make those seeking faith healing vulnerable to abuse. There are a number of 'quacks' in Pakistan and other countries who take advantage of the vulnerable and abuse the practice of traditional healing. Local newspapers frequently publish reports of malpractice among faith healers, traditional practitioners (Herbalist or Hakeem) and alternative practitioners (homeopaths and Chinese Medicine). The Herald (1993) (a popular monthly Pakistani magazine) and BBC news reported a Hakeem in a town of the Punjab, Pakistan who treated people with mental health problems by bloodletting (Bennett-Jones, December 4, 1998). There are also reports of faith healers treating their clients with holy water (holy verses read upon a container of water) that had been spiked with antipsychotic medication (Haloperidol) which is readily available over the counter at any chemist (personal experience and communication, 2004). The BBC news reported an incident of a teenager; a sister of mentally ill boy who was raped and abused by a faith healer who was treating the boy. The healer denied all the claims and the matter was never investigated by the criminal justice system (Gregorius, 15 July, 1999). Reports of physical beating, sexual abuse, sexual harassment, and torture at some shrines

(Malik and Bokharey, 2001) are common, thereby reinforcing a negative image of faith healers in some quarters. Despite these tales, and the obvious risks involved, services offered by faith healers in general are widely trusted and accessed by a large section of the population.

STUDIES OF MENTAL HEALING AT SHRINES OR TEMPLES

A few studies have been conducted exploring the nature of illness/problems for which an individual or family seeks help from religious venues such as temples and shrines. While some record mere observations of people's stay while receiving healing (Pfleiderer, 1988 ; Hussain et al., 2001 ; Malik and Bokharey, 2001), others explore the problem from the perspective of clinical psychiatry and attempt to measure distress using psychiatric screening tools (Raguram et al., 2002). Exploring attendees' reasons for attending the shrine and their healing experience is an area rarely studied and it is suggested, requires further investigation (Padmavati et al., 2005).

In Tamil Nadu, India, the temple of Muthusamy is considered a community resource, where people with serious mental health problems come and stay for varying periods. In their study, Raguram and colleagues (2002) found that during their stay, the attendees (assessed by a research psychiatrist and diagnosed as suffering from severe and enduring mental health problems) were encouraged to just be there and take part in the daily activities of the temple, including attending brief prayers in the morning and cleaning the temple compound or watering the plants. With a minimum of 5 weeks stay, even in the absence of any active treatment/ healing rituals, significant improvements were noted.

Malik and Bokharey (2001) report their observations and interventions at a shrine in Lahore, Pakistan, which was attended by thousands of people, seeking healing for mental distress. Although the caretaker reported that thousands of clients were cured by the saint of the shrine, the authors witnessed the condition

in which attendees' with 'problems' were kept in the shrine - at times tied with metal chains for unspecified periods. The authors considered the situation to be extremely distressing, diagnosed people to be suffering from a variety of mental health problems and intervened by dispensing a variety of psychopharmacological agents. It was interesting that no attempts were made to understand or explore attendees' preference for seeking healing at the shrine in the first place. They did not mention whether the attendees experienced any benefit from being at the shrine and if there had been a change in their symptoms. In addition, how the problem would be further managed at home or in the community was not discussed.

In an observational study in Nawabshah, also in Pakistan, Hussain et al (2001) found a significant number of people attending shrines for the healing of mental and physical ailments. The researchers concluded that what gave shrines their status as a health resource was their association with the Sufis. By performing rituals, attendees experienced healing through the submission of wishes, catharsis (through crying, weeping, and acting out) and open requests for support and help. The authors have not included any details of the data collection, whether it was gathered only through observation or whether they also interviewed attendees at the shrine.

Padmavati et al (2005) who conducted a study at five shrines, both Hindu and Muslim, in India, concentrated on exploring the reasons for seeking help at these shrines. A total of 26 participants suffering from schizophrenia, and/ or their relatives were interviewed. Explanations for the illness focused largely on supernatural forces and possession. Their help-seeking at the shrine was therefore linked to their explanation as the shrine sought to promote religious rituals and support from a higher being. Many attendees had either never sought medical help or discontinued it promptly as they perceived it to be inappropriate or harmful.

Pfleiderer (2006), following her 18 month long research in a north Indian shrine in the late 1970's, reported the phenomenon of trance and possession among attendees at the Mira Datar Durgah. This state of trance was referred to by the attendees as '*Hajri*' and was a key part of the healing process. In the same research Pfleiderer (1988) translated the term '*paagal*' as 'mentally ill'. It is however, important to remember that this is an etic perspective of the researcher on the observed state or behaviour. In the context of Pakistani culture, and in Urdu/Hindi language, the term '*paagal*' refers to 'madness' therefore referring to a state of mind and not an illness of mind. There will always be difficulties when trying to translate language and concepts from one cultural system to another.

Faith healers are clearly important sources of help for those suffering mental distress and religious healing venues are commonly used by followers of all the major religions. They are popular for a variety of reasons including the acceptability of the treatment they offer, affordability and cultural 'fit'. They are particularly consulted by those who consider themselves 'possessed' and the research has identified a large proportion of those consulting faith healers to be suffering from 'mental disorder' in a western psychiatric sense. The relationship between the faith healer and client has been described in terms of a therapeutic relationship or process. Other literature has highlighted the potential for actual abuse of vulnerable people who seek help in this way although this does not seem to have affected its overall popularity.

There have been a few previous studies of mental healing at shrines, or temples, the focus of which has been on why or for what problems people came to the shrine, often using psychiatric screening tools to diagnose problems. Some studies report improvement in attendees' well-being whilst other researchers have felt obliged to intervene pharmacologically once on-site.

The exploration of people's reasons for attending shrines and their lived experience once they are there have rarely, if ever, been considered. This is a clear gap and requires further investigation if healing processes at religious shrines are to be understood.

RELIGION AND MENTAL HEALTH

Harold Koenig, and Kenneth Pargament, professors in psychiatry and psychology are considered leading research authorities in the field of religion, religious coping, and health outcomes. Although most of Koenig's work is with older people belonging to the Christian faith, it provides important insights into the role religion, and religious coping play in the context of health outcomes (Hsu, 1995). Moreira-Almeida, Neto & Koenig (2006) examine the relationship between religiosity and mental health, reviewing evidence available largely based on the handbook of religion and health (Koenig et al., 2001). This handbook presents a systematic and comprehensive review of more than 1200 studies published during the 20th century assessing the relationship between religion and health outcomes. There is not yet a single definition of what religiosity is and how it impacts on the health of the individual, however, variables assessed often include church attendance, non-organisational religiosity (time spent in private, engaged in religious activities such as prayer, meditation, and reading religious texts), and subjective religiosity (the importance of religion in one's life). The results described often involve extremes in terms of either being for or against religion.

Traditional beliefs and religion play an important role in the life of people in Islamic cultures. Faith rituals such as prayer, attending a place of worship or carrying out religious practices can give structure and meaning to life, often in a supportive environment and are positively linked with increased life satisfaction and quality of life (Flannelly and Inouye, 2001 ; Khowaja, 2001 ; Koenig et al., 2001). Individuals and families seek religious healing to improve their mental, physical, emotional, and spiritual health (Yousaf, 1997) and religious coping is a

common coping strategy employed to deal with mental distress (Hussain and Cochrane, 2003). Many faith healers practice where people hold strong traditional and religious beliefs and values in all aspects of their lives (Saeed et al., 2000). Strong belief and expectancy has been correlated with positive outcomes in spiritual healing experiences. In a study by Wirth (1995) users and providers of spiritual healing were assessed for their level of belief and expectancy in their hope for recovery in 3 weeks. The results showed that stronger beliefs and expectancy for recovery had a significant impact on reducing depression and anxiety among users of spiritual healing. For physical ailments, the results were not significant as the ailments were often chronic in nature and three weeks was not a sufficient time period in which to effect significant improvement.

For believers, religion provides a framework for moral and ethical living. Congregations, mass meetings, or religious gatherings provide them a context in which they feel united and harmonised and reinforces their devotion to their creator. Rhythmic drumming or praying was/is a common method used in Sufi congregations to promote feelings of harmony, inner peace, and togetherness and to induce trance like states referred to as 'Zikr' or 'Hulqua'. At times of distress and suffering, religious institutions and teaching become more widely sought resources for a person seeking equilibrium and peace in their life. Addresses by the healers, Sheikhs or priests may provide emotional support and a sense of guidance to distressed listeners and for those suffering from anxiety. It may also lead to trance like dissociative states where people experience temporary relief from mental stress. Those with chronic psychosis or schizophrenia may derive a feeling social support and a sense of belonging (Baasher, 1982).

Religious beliefs can provide support through enhancing acceptance, endurance, and resilience. While they can generate peace, self confidence, purpose, forgiveness, and positive self image, they can also bring guilt, doubt,

anxiety, and depression through enhanced self-criticism (Koenig et al., 2001). In his review of studies, Koenig identified religious patients using more positive coping strategies such as trying to find a lesson from God in the distressing event; doing what one can do and leaving the rest in God's hands; seeking support from clergy/church members; viewing one's life as part of a larger spiritual whole; looking to religion to find a new direction for living when the old one may no longer be viable; and attempting to provide spiritual support and comfort to others. While these coping strategies had a positive impact on health outcomes, there were also negative and damaging coping strategies used by religious people that included waiting for God to control the situation, redefining the stressor as a punishment from God, and questioning God's love.

Campion and Bhugra (1997) found that faith rituals such as prayer, attending a place of worship or carrying out religious practices played a significant role in the treatment of mental ill health. According to Cinnirella and Loewenthal (1999), personal prayers are considered one of the most important coping strategies for dealing with not only day-to-day mental distress but also with mental health problems such as depression and schizophrenia. It is believed that Allah/God will listen to requests for help in prayers and act upon them, and having this knowledge becomes a source of great comfort. In addition, prayers can also provide an opportunity to offload responsibility for dealing with one's trouble onto God. The authors highlight the contradiction in the role prayers play for people. On one hand they serve as personal therapy, giving the one praying control and making them self efficacious, while on the other hand they involve the giving away of one's problem to the higher being.

Pargament (1997) suggested that religious coping can be helpful, harmful, or irrelevant in one's life depending upon the nature of coping and how it is used. A longitudinal study by Pargament and colleagues (2004) explored religious coping and spiritual, physical, and psychological functioning among 268 medically ill, elderly, hospitalized patients, with follow up after two years. Many

positive religious coping strategies such as ‘seeking spiritual support’ and ‘benevolent religious reappraisal’ were associated with positive health outcomes, whereas some coping methods were labelled negative such as ‘punishing God reappraisals’, and were predictive of a decline in health. Those experiencing spiritual discontent and feeling punished showed decreased independence in daily functioning, poorer cognitive functioning, poorer quality of life, and more depressed mood at baseline and at follow up. Interestingly, some of the negative coping such as passive religious deferrals, marking religious boundaries, and pleading for an intercessory had a positive impact on some health aspects and negative on others. Demonic reappraisals are considered to be negative religious coping methods and showed negative impact on functional status and quality of life although it was associated with better spiritual outcomes for the study participants. What is important to remember in this argument is the context – the study, the tool used and concepts around positive and negative coping described and examined here are in relation to Christianity and western thinking and therefore may not be totally applicable in the context of Islam and culture. However, it is clear that religious coping can be both positive and negative.

The literature in this area remains largely inconclusive in terms of the definitive effect of religion on mental health. However, it is evident that certain aspects of religious coping do lead to more positive health outcomes for religious individuals whereas for others they do not, and can even be negative. Outcome appears dependent on context and the type of coping strategy employed.

PILGRIMAGE AND ITS ROLE IN HEALING

According to Rees (2003), “pilgrimage is the journey to a spiritually charged centre. The journey may be easy or hazardous, sombre or festive, short or long, but whatever their outwards form it is an important institution in all the world religions” (p. 35). Pilgrimage is also a journey that entails movement from one aspect of life to another, resulting in a transformation. Religious pilgrimage in

particular can be viewed as a “a movement from the profane to the sacred, from everyday life to an encounter with the divine, or from local, conventional religion to a radiant religion experienced in a far off place” (Gesler, 1996 p. 96). Turner and Turner (1978) associate pilgrimage with a ‘rite of passage’ that encompasses the individual’s separation from a stable set of relationships, followed by a period of liminality (or ambiguous state) and then a return to the same social system but with a new identity.

There are a number of pilgrimages associated with the major religions. One such pilgrimage related to powerful healing takes place at Lourdes (France). Since 1700 Lourdes has attracted millions of visitor each year who make a pilgrimage in the hope of obtaining healing for chronic, incurable, and severe medical conditions. Those suffering from various physical and emotional illnesses are taken there in the belief or hope that healing can be achieved and suffering eased through this pilgrimage. Kumbh Mela is another traditional pilgrimage, which takes place every 12 years and attracts millions of Hindus from all over the world to the sacred rivers in northern India where they believe they will be healed and their body and soul purified. For Muslims, the annual pilgrimage to Al-Ka’bah (*Hajj*) in Mecca is considered one of the five pillars of Islam (Rees, 2003).

A study by Morris (1982) indicated that as a result of the strengthening of faith, associated with the visit to Lourdes, people, even with serious illnesses achieved reduced levels of anxiety and depression which they sustained for a significant time period post-visit (cited in Rees, 2003). It is suggested that what actually contributes towards improvement in a person’s health may not be understood from the medical perspective and will therefore remain unverifiable. However, what should be noted is the relationship which a person or family develops with the place of healing or healer and the subjective improvement or benefit to him/her rather than scientifically verifiable evidence (BBC-Radio4, 2008).

In a European context, an important motive for pilgrimage has been expiation from sin. People in medieval times regarded evil spirits as being responsible for their ill health and making a pilgrimage and confessing their sins was believed to bring improved health and better outcomes (Gesler, 1996).

According to Turner and Turner (1978) pilgrimage requires people to “move from their everyday life and structured roles and statuses to a world of ‘communitas’ and ‘antistructure’ through the ritual celebration of their common and universal humanity” (cited in Eade, 1992). It is suggested that through pilgrimages, people enter into liminoid states where emotional release can be attained from the world of everyday structure. Victor Turner first introduced his theory of ‘liminality’ in 1967, drawing heavily on Van Gennep’s (1909) three-part structure for rites of passage. For Van Gennep, the liminal phase was a place in which there could be some liberation from social norms. The word ‘liminal’ is derived from the Latin term for threshold, and Turner proposes it as a crucial component of his concept of liminality. Turner defined the liminal fields to be “a gap between the ordered worlds where almost anything may happen... the possibility exists of standing aside not only from one’s own social position but from all social positions and of formulating a potentially unlimited series of alternative social arrangements” (1974 p. 13-14).

Real or symbolic thresholds are very important components of ritual and symbolic experience. At these points the subject (liminal) is socially and structurally ambiguous and “between the fixed point of classification” (Turner, 1967 p. 95). Liminal beings (those undergoing rites of passage) have no status, property, role, or position in a kinship system. The liminars are stripped of status and authority, removed from a social structure that is maintained and sanctioned by power and force, and levelled to a homogeneous social state through discipline and ordeal. In *liminal* spaces a person can stand outside of their normal social roles and embrace alternative social arrangements and values. Turner (1969) proposed that “liminal entities are neither here nor there;

they are betwixt and between the positions assigned by law, custom, convention, and ceremony” (p. 95).

All sites of pilgrimage are believed to be places where miracles once happened, still happen, and may happen again. The believers firmly consider that faith is strengthened and salvation secured by personal exposure to the beneficent unseen presence of the Blessed Virgin or the local saint (Rees, 2003). It is suggested that for the majority, pilgrimage is the great liminal experience of religious life. Gesler draws attention to the fact that most of the pilgrimage sites are located in peripheral or isolated geographical areas. By being away from home at the pilgrimage sites allows or enables pilgrims to sever their contact with everyday life and this helps in bringing about transformation in their life (Turner and Turner, 1978 ; Gesler, 1996).

Although the notion of true ‘communitas’ is challenged by some authors (Eade, 1992), it is clearly of interest in the context of the experiences of attendees at shrines and other pilgrimage sites. Liminality as a concept is also useful in exploring journeys or movement towards another state of being whether physical or spiritual.

THERAPEUTIC LANDSCAPE

Following on from the literature addressing the role of pilgrimage, leads to consideration of the importance of ‘place’ in the healing process. The concept of a ‘therapeutic landscape’ was first introduced by Gesler (1992, 1993, 1996, and 1998) and is a recent addition to the field of health geography. It addresses the ways that people have traditionally sought healing in certain places, settings, locales and situations. Therapeutic landscapes can also refer to or include “changing places, settings, situations, locales, and milieus that encompass both the physical and psychological environments associated with treatment or healing” (Williams, 1998 p.1193).

Gesler (1996) explores the notion of health in a particular place or geographical space and how the meaning that people give to their experiences of health reflect on particular places and how places, in turn, influence perceptions and experiences concerning health. Gesler (1993) describes how a therapeutic landscape emerges when 'physical and built environments, social conditions, and human perceptions combine to produce an atmosphere that is 'conducive to healing' (p. 96). Therapeutic landscapes have a 'sense of place' associated with them that is conducive to healing and restorative. However, the curative or restorative attributes assigned to them are not necessarily dependant upon any particular element within the environment but are closely linked to the individual or group that is constructing the notion of that place (Williams 1998). Landscape is a source of identity and security, as well as the setting for daily life (Porteous, 1990 ; Gesler, 1992 ; Gesler, 1993). Milligan et al (2004) suggest that specific landscapes not only provide an identity, satisfying a human need for roots, but can also act as the location of social networks, providing settings for therapeutic activities.

It is suggested that a therapeutic landscape is not only a function of a physical and built environment modified by human action (Williams, 1998), but also "a product of the human mind, and of material circumstance," and something that reflects "both intentions and actions and the constraints and structures imposed by society" (Gesler, 1992 p. 743). Popay et al (2003 p. 56) note that places represent, "the canvas on which shared social meanings are constructed and interpreted." Individuals are therefore instrumental, both consciously and sub-consciously, in creating and being influenced by the environment or landscape in which they live. "It is through lived experience that moral, value, and aesthetic judgments are transferred to particular sites which, as a result, acquire a spirit or personality. It is this subjective knowledge that gives subjective places significance, meaning and felt value for those experiencing them" (Williams, 1998 p. 1197).

The therapeutic landscape cannot easily be reduced to the simple physical, social, or symbolic properties of the 'place'; rather it is the interaction of these in the particular context of the healing or restorative process which makes places more or less therapeutic (Martin et al, 2005). For Gesler it is a "constantly evolving process, moulded by the interplay, the negotiation between, physical, individual, and social factors" (Gesler, 1992 p. 743).

Over the last 15 years, the concept of the therapeutic landscape has been explored within a range of fields and settings and research has examined a variety of landscapes including mountains (Palka, 1999), woodlands (Milligan and Bingley, 2007), and the significance of sacred places or sites of spiritual pilgrimage, such as Lourdes in France (Gesler, 1996) and Native American landscape (Dobbs, 1997). It is increasingly appearing in different disciplines including nursing.

The study of therapeutic landscapes has improved understandings of health and place and their interaction and how they contribute to healing. Within the literature the types of places associated with healing fall under two main headings; those relating to 'extraordinary' landscapes and those representing the 'everyday landscape' of healing. 'Extraordinary' landscapes refer to those therapeutic landscapes that are located outside day to day living experience and often associated with extraordinary events in people's lives. 'Everyday' landscapes are those that form part of everyday living and are not experienced as unusual or out of the ordinary (English et al., 2008). Much of the literature has examined the 'extraordinary' therapeutic landscape (shrines, spas, baths, and ancient healing sites) but has more recently focussed on the 'everyday landscapes' of home and community.

While 'extraordinary' landscapes of healing, such as hospitals or spas, represent sites in which "people may enjoy a high quality of life for a short time" (Gesler, 1992 p. 738) these landscapes are not intended to support long term

connections to health and healing but give short term boosts. However, 'extraordinary' landscapes in combination with everyday encounters with places such as home and the community may be important for long term healing, particularly for people experiencing chronic illnesses (English et al., 2008). Whilst this argument has merit it does not account for the potentially miraculous and sometimes permanent healing that is believed to take place at an extraordinary venue, such as a religious shrine (many miracles have been documented at Lourdes for example).

Gesler and Gordon (1998) suggest that "places achieve positive or negative reputations because people perceive that they do or do not fulfil basic needs such as providing security, a feeling of identity, material wants or aesthetic pleasure"(1998 p. 17). Wakefield and McMullan (2005) go on to argue that the development of reputation or image also depends on the relational aspects of place: for example, how a place interacts with or is positioned within existing social and economic structures. They also give importance to how places are perceived by those outside as well as those within their boundaries. It is clear that the images or reputations that different places have are grounded in social processes and power relations.

Boundaries serve to identify, separate and contain stigmatised places, ensuring that their presence does not affect identities created in adjacent places (Douglas, 2002). As a result of this process stigmatised places and the people who live in them, may be excluded and stereotyped in such ways that facilitate and even justify their exclusion (Craddock, 1995, cited in Wakefield, 2005). Geores and Gesler (1999) while analysing the treatment of people with mental health problems in hospitals discuss how treatment is provided in a context where their civil liberties are removed in a concern for the public safety. The authors consider people with mental health problems to be at a distinct disadvantage because they cannot always choose the type of treatment they will receive and where would it be given. Treatment in a custodial setting takes away the element

of 'therapeutic' from the environment. This raises a question as to whether a hospital or custodial setting for people with mental health problems can ever be a truly therapeutic landscape (Relph, 1976).

Wakefield and McMullan (2005) argue that it is possible for places to simultaneously hurt and heal. Even in the most stigmatised places, those considered very unhealthy by outsiders, one can still identify positive health attributes of the place. Therapeutic landscapes or spaces of care may be perceived differently by different people. Nairn (1965, p. 78) recognises that "there are as many identities of place as there are people (quoted in Relph, 1976). What is positive and healing for one person can be harmful for another. This has also been described in terms of an 'authentic' as opposed to 'unauthentic' landscape (Relph, 1976).

Milligan and Bingley (2007) suggest that most research in this field has focused on attempting to understand the positive elements of environments that contribute to human health and well being. They go on to suggest that what is missing is an understanding of: a) how such environments can be differentially experienced by individuals (what is therapeutic for one person may not be another); and b) the key influences that affect people's perceptions of the therapeutic quality of landscape. Conradson (2005) emphasises the need for focus on the therapeutic landscape experience or therapeutic encounter and suggests it is best approached as "a relational outcome, as something that emerges through a complex set of transactions between a person and their broader socio-economic setting" (p. 338). He advocates that often the element of 'therapeutic' in these instances is associated with the 'self-landscape encounter' rather than the landscape itself. Davidson & Milligan (2004) suggest that our sense of ourselves, who and what we are, is continually being shaped and reshaped by how we feel and that meaningful senses of space emerge through movements between people and places. Lourdes' reputation as a therapeutic place is intimately linked to the complex discourses that have

developed around it as a site of spiritual pilgrimage. Its construction as a place of healing is sustained and reinforced by personal visits, subsequent interpretation, re-telling the story of the visit, and a Catholic Church narrative.

‘Therapeutic landscape’ as a concept is clearly relevant to any exploration of healing at a religious venue. The literature highlights the importance of place, social conditions and human perceptions in combining to create an environment that is ‘conducive to healing’. It is also interesting to note that a place which is healing or comforting to one person may have the opposite effect on another. Further study of the nature of the ‘therapeutic encounter’ is also called for.

FACTORS INFLUENCING CHOICE OF HEALING RESOURCE

Explanatory models of illness, socio-cultural and economic background, the availability of alternate resources, cost, previous experience with health care providers and stigma, all seem to contribute to the choice of help-seeking and the family as collective decision-maker for individual members is key to that choice. “The social aspect of illness, like the physical, mental and medical aspects, represents a time sequence. There is a beginning, an awareness of the first faint symptoms; there is progression, the social and physiological processes that occur; and there is a termination, through recovery or death. At many points during the course of illness, medical and social decisions must be made, roles readjusted and attitudes changed to conform to the reality of the situation” (Foster and Anderson, 1978 p.146). So it is that multiple factors apply at different stages in the identification of illness and choice of health resource.

A study exploring the perceptions of Pakistanis who had lived in the UK for over a decade found that up to 35% of the participants’ related causes of mental health problems to the supernatural and considered faith healers to be the preferred source of treatment (Tabassum et al., 2000). This choice may be a

cumulative result of influences from family members, previous experiences, and the feasibility of accessing or opting for the treatment. While in developing countries access to these types of treatment is easier and more affordable, its use may decline when it becomes more expensive and harder to find (Hilton et al., 2001).

Similar preferences were shown by participants in other studies carried out among an Asian population residing in the UK (Healy and Aslam, 1990 ; Dein and Sembhi, 2001 ; Khan and Pillay, 2003). Faith based practices or traditional healers were perceived to heal by linking the mind, body, and spirit more than Western psychiatry. The popularity of faith healing may be due to the healer's shared beliefs regarding causation of illness and willingness to include the family in the treatment alliance. The study could have been enriched if the authors had explored whether it was strong beliefs around causation and treatment of mental health problems or an inability of mental health care providers to offer culturally sensitive or competent care that led participants to choose faith based healing. Moreover, the authors also failed to discuss the possible existence of parallel explanatory maps for causes and treatments of mental health problems. The authors suggest that living in a western society may have begun to alter the *emic* model of the causation of mental health problems as one of the respondents stated that belief in the supernatural causation of mental health problems is much commoner in Pakistan. While the explanatory model of patients and their families includes supernatural causes and leads to consideration of spiritual healing as an appropriate healing pathway, some mental health practitioners continue to label this type of healing as 'inappropriate and detrimental to health' (Zafar et al., 2008)

A survey in India (Kakar, 1982), revealed that 90% of a sample of people, who had experienced illness symptoms, relied on home remedies or other forms of self help. People from higher castes were more inclined to say that natural causes played a part in causing illnesses whereas lower castes believed more in

supernatural forces such as jinn and witchcraft. Other important factors affecting help seeking for psychiatric illnesses included educational background, social class, and religious affiliation as well as religious attendance.

Some families choose not to seek treatment for mental health related problems and accept the limitations in the occupational functioning of the sufferer and compensate for it through the work of other family members. As long as equilibrium can be maintained, they show no interest in seeking treatment (Thara et al, 2004). Many studies suggest that women are represented more than men among the patients of faith healers. This has been linked to economic power and the availability of financial means (Saeed et al., 2000 ; Chadda et al., 2001 ; Farooqi, 2007). The choice of healing resource also has an impact on the level of stigma that a person experiences. Warner (1986) describes a pattern amongst Puerto Ricans, who if they go to a psychiatric clinic or asylum are likely to be stigmatised as ‘madmen’, however, if they consult a spiritualist, they may experience a rise in their status.

In his study carried out in an Indian village, Kapur (1975) found that the participants effectively recognised mental health symptoms in themselves and in their family and consulted multiple healers to achieve comfort and healing. More healers were contacted if the symptoms were two or more. In his study of more than a thousand adult participants, 30% of male sufferers consulted doctors, and 23% consulted indigenous healers, whereas 38% consulted both sorts of healers. Among female sufferers, the percentage was 42%, for doctors, 10% for traditional healers, and 48% for both. In this study doctors were in general preferred over the traditional healer; however, there was only one particular doctor who was consulted by the whole village. Although other doctors who were based at primary health care centres were accessible and offered free consultations and medicine, their popularity and use remained limited. This highlights the importance of the reputation of the healer rather than the treatment model or framework or the cost of services in making a

choice. A recent study carried out in two urban hospital out-patient departments in Pakistan described how patients placed a great value on the psychiatrist's ability to listen to their concerns and describe the cause and course of their illness (Channa and Siddiqi, 2008). A healer's ability to listen and give time is very important, although frequently ignored in an allopathic setting. A focus on the patient and the time given to talk about the problem is an important factor in the selection of a healer.

STIGMA

Stigma refers to "a relationship of devaluation in which one individual is 'disqualified from full social acceptance'. It is an attribute that is deeply discrediting and indicates an experience of shame and disgrace" (Thara and Srinivasan, 2000 p. 135). Acquiring a mental health problem can sometimes be perceived as a sign of 'not being a good Muslim' and invites dishonour and stigma from the community. A study by Cinnirella and Loewenthal (1999) exploring ways of coping with mental distress among older people in north London, described a Muslim participant who said '...a good Muslim will not slip into deep depression....' (p. 517). The stigmatised person may experience social distancing from others who are not ready to accept them as full members of society. Social stigma attached with mental health problems at both an individual and family level in Pakistan strongly discourages individuals from even acknowledging mental distress in terms of illness (Karim et al., 2004).

Goffman (1963) describes how for each person a virtual social identity is held in other peoples' minds before they actually meet them. This 'virtual social identity' is based on 'normative demands' although those holding this identity may not be aware of it. At the time of an actual encounter with the person, his/her 'actual social identity' becomes more apparent. In cases where actual social identity does not meet the normative demands, the person can be reduced in peoples' perceptions from a whole and usual person to a thoroughly bad,

dangerous, or weak person. This attribute becomes stigmatising especially when its discrediting effect is extensive. However, it is not necessarily the case that it is the attribute itself that is 'always' negative, but the very fact that it is different from what is expected, makes it negative. Being diagnosed as having a mental health problem not only brings shame and negative consequences for the individual, but colours the reputation of the whole family in the community. This finding is apparent among different ethnic minority groups in the UK including African Caribbean people, Jews, Muslims, and Hindus (Cinnirella and Loewenthal, 1999). Stigma serves as an additional factor discouraging people from seeking support or help from other members of their own communities.

Cultural rules and values also influence the experience of shame, subordination and entrapment and their impact on mental health. Cultural and social groups define the characteristics and behaviours that bring shame and stigma and these vary from culture to culture. Moreover, "the dynamics of shame and stigma may be linked to complex power and self-interest interplays between people. For example, shame–honour systems of one gender can impact on another. This is related to notions of control in that failure to control that which one is seen to own or be responsible for (one's children or wives) can result in stigma" (Gilbert et al., 2004 p. 10).

Stigma assigned to those people with mental health problems and their families is deep rooted. Al-Adawi et al (2002) explored the perceptions and attitudes of people towards mental illness in Oman. Participants included groups of medical students, the general public, and carers of the mentally ill. Findings suggested that there was no significant difference in the stigma each group assigned to mental illness based on appearance and peculiar behaviour and they all rejected genetic predisposition and favoured supernatural forces as the cause of the problem. They all suggested that psychiatric treatment facilities should be located away from the community. In a Nigerian sample, higher literacy levels

were found to be correlated with positive attitudes towards the mentally ill and this echoes findings from Ethiopia (Kabir et al., 2004).

An analysis of a large collection of studies highlights how people with mental health problems are perceived and appraised by the general population (Lauber and Rossler, 2007). It identifies generally negative perceptions and attitudes of rejection of the mentally ill. The authors noted that people widely held views that people with schizophrenia are aggressive and therefore a serious threat to safety and should be locked away. Those suffering from schizophrenia felt isolated, discouraged and 'hidden away' from others so as not to cause embarrassment to the family unit.

A study by Thara and Srinivasan (2000) in Chennai, India, explored the extent to which stigma was experienced by the primary caregivers (PCG) of chronic schizophrenics. The results showed that 38% of PCG experienced a high level of stigma. They experienced grief and depression due to the illness, saw ruined marriage prospects for other family members, were treated differently by their neighbours, and blamed themselves. About 35% of the respondents could not explain the cause of the illness, whilst others considered interpersonal relationships, lifestyle or supernatural forces to be responsible. Interestingly, high levels of stigma were common among those who were the PCGs for young women.

A study in Germany of Turkish Muslims attempted to examine the correlation between anticipated stigma and experienced stigma in patients suffering from schizophrenia or depression. Findings suggested that the patient anticipated a much greater level of stigma than was actually experienced. For most people stigma manifested itself in the form of interpersonal rejection (Matthias et al., 2004). The same level of discrimination was experienced whether a person lived in a large city or a small town. Patients with schizophrenia experienced more instances of stigma and discrimination than those who were depressed. The

high level of anticipation of stigma leads to avoidance of social roles and services. Low scores in 'experiences of discrimination' do not necessarily indicate a better awareness among the general public or a change of attitude, but may signify that people with depression or schizophrenia avoided circumstances where they believed there was a chance of experiencing discrimination or embarrassment.

Findings from a large scale study in Pakistan suggested that when an individual is affected by a mental health problem, the whole family is affected and perceived as pathological. As a result, social invitations are withdrawn and when invitations are extended, the family distances themselves from them in order to avoid social embarrassment (Suhail, 2005). The study also revealed that only 3% of the participants would consider marrying a person who is depressed or psychotic and only 5% would have them as a friend. The social stigma was far greater for a person with psychosis. Mental health problems were neither accepted nor acknowledged as a 'medical problem'.

Lauber, Nordt, & Rossler (2005) report that the stigma and the resulting effects of rejection, humiliation, and isolation discourage people from seeking help from psychologists and psychiatrists and forces them to resort to hiding the 'illness' or distancing themselves from others to prevent gossip and the collapse of respect (cited in Lauber and Rossler, 2007).

From the literature it is clear that the stigma associated with mental ill-health or shameful behaviour, threatening family honour, is strong and a serious disincentive to help-seeking. This is true in many cultures. The stigma not only affects or discredits the individual but also the whole family. As a result of anticipated stigma there is a withdrawal from social interaction and community in an attempt to avoid embarrassment.

MENTAL HEALTH AND FAMILIES

Families play a significant role in caring for their mentally ill relatives in Pakistan. All financial, moral and human costs are borne by family members (Karim et al., 2004). Decision-making concerning the state of a person's health and help-seeking is a collective one. The family may protect, guard, shield, or reject the patient depending upon how the illness is perceived. Significant stigma attached with mental health problems may push some families to maintain secrecy about the illness or 'problem' and not to seek help. More positively, help-seeking can begin at an early stage when the person is taken to a healer or other community resource. In cases where a person is admitted to hospital at least one family member will stay with them. The approximate duration of an inpatient admission is on average 18 days (Gadit and Khalid, 2002) thereafter the family will take on the caring role at home. The family system in Asian cultures offers crucial support to those suffering from mental health problems (Thara et al., 2004).

From a sociological point of view, Pfleiderer (1988) has noted that when a person's functioning is impaired or an alteration in behaviour evident, high levels of helplessness and anxiety are experienced as the family strives to understand the nature of this disturbance. Consulting medical doctors leads to identification of that disturbance as 'an illness', however it does not change the disturbance created within the family system. Consulting a faith healer can, on the other hand, provide a broader or more family oriented approach to care as the focus of attention is the distressed individual, his/her family and their social circumstances. Families are key in not only caring for those family members suffering ill health but also in deciding when and where to seek help.

USE OF PLURALISTIC HEALTH CARE RESOURCES

A comprehensive review (Halliburton, 2004) of the literature highlights the use of alternative therapies in the developed as well as developing world. However,

it is suggested that biomedical therapies dominate in the West as they are more easily accessible and generally available. The use of alternative therapies is often costly and requires greater effort to locate a therapist. The situation is very different in developing countries like India and Pakistan where alternate systems of healing are more readily available and accessible (Halliburton, 2004). Halliburton, while following three groups of people using Ayurveda, medical treatment and religious healing found that some patients had changed their treatment from Ayurvedic to allopathic or to a religious healing method and vice versa and that this change in treatment was motivated by a lack of improvement, experience of side effects, and a perceived inappropriateness of therapy. Although each group reported some improvement, people often responded quite differently to the same form of treatment. A number of people changed their treatment from one source to another based on research, inquiries made by their relatives and positive reports from others who had used the service. For those using religious therapy, it was not strong religious beliefs that encouraged its use, but its ability to 'fit' with an overall lifestyle, values and beliefs and social system of the patient. Halliburton (2003) considers medically pluralistic societies (often existing in the developing world) to be one explanation for the better outcomes that schizophrenic clients have in the developing world (WHO, 1973 ; Sartorius et al., 1986).

The use of alternative therapy, parallel to psychiatric treatment is also common among patients admitted to psychiatric hospitals. Assion et al. (2007) in his study in Germany found that patients used at least one unconventional therapy, while alternative medicines were favoured by the native group. The migrant group studied (mainly Turkish Muslims) used traditional and folk medicine and healers (four times higher than the native group). Their use of traditional healers was related to their beliefs around illness that included 'animistic ideas of personalised, supernatural powers like devils, demons, or djinn' (p. 224).

The use of traditional healing methods by Asian populations living in the UK has been highlighted by various authors (Healy and Aslam, 1990 ; Tabassum et al., 2000 ; Dein and Sembhi, 2001 ; Khan and Pillay, 2003). Use of *Hakeems* (herbalist) was very common and the problem about which the consultation was made was often for what was called 'sexual anxiety'. When supernatural possession was diagnosed, a referral was made to a Mullah (religious healer) who used amulets to treat the problem. Interestingly, most of the patients first consulted their GPs about the problem; however, failure to achieve improvement led them to consult *Hakeems* and other traditional healers (Aslam, 1979 ; Healy and Aslam, 1990).

Dein & Sembhi (2001) report, in their London based study of people from South Asia who were receiving care from a community mental health team, about a third consulted traditional healers about their psychiatric problems, about 20% for their non-psychiatric illness and about 15% used traditional remedies to help with other ailments. Many also wanted to consult traditional healers but did not know how to go about it in the UK. It was clear that most of the patients used traditional resources alongside psychiatric treatments, perhaps as the medications were available for free. While some said they understood the ways in which traditional herbal prescriptions worked, others were less sure and were looking for more of a 'quick fix'.

The literature highlights that treatment availability, cost, perceptions of illness causation, 'fit' of treatment with explanatory model, the relationship between healer and patient and stigma all contribute in varying degrees to choice of healer or healing resource. The family is the key decision-maker. When their attempts to contain disturbance caused by the illness or behaviour of a family member, and to maintain or regain equilibrium fail, they are forced to make a choice to seek help. A treatment that is family oriented is likely to be favoured. However, the literature also shows how individuals or families can change or modify their choices in response to the perceived failure of a particular

treatment, unpleasant side-effects and lack of 'fit' with overall beliefs and lifestyle. The use of psychiatric and alternative therapies concurrently is not uncommon and the presence of medical pluralism may contribute to the better outcomes for people with mental health problems that are achieved.

SUMMARY

It is clear from this wide-ranging review of the literature pertinent to the area under study, that previous research has largely approached and explored the role of religious faith and shrines from the point of view of those who end up using organised health care facilities to seek further healing and conclusions are drawn from this subject group.

The literature concerning the significance of faith healing rituals and their impact on mental health among Muslims, especially in the Indian subcontinent shows a focus on faith healers' characteristics, their mode of diagnosis and treatment strategies, estimating the prevalence of mental disorder among shrine attendees or the description of belief systems around mental health problems (Khan and Pillay, 2003). The studies highlight continuing preference for faith healing, whether in Pakistan or in the UK (Tabassum et al., 2000 ; Gadit and Khalid, 2002). However, the choice of religious healing is mostly viewed from the position of western psychiatry and diagnosing or treating people rather than understanding their explanatory models, why they seek help in a particular way and how it helps them (Saeed et al., 2000).

The pathways to care and help for mental health problems selected by individuals and families are clearly influenced by culture and religion and beliefs about illness causation and remedies. Religious healing and shrines are major health resources in many Muslim countries and in the Indian Subcontinent. The literature demonstrates the complexity of illness experience and perception.

What is missing from the literature are the voices of those who use, whether by active choice or not, religious healing venues and an examination of their lived experience at a shrine or temple. The literature on 'therapeutic landscape' highlights the interaction between place and health in 'extraordinary' landscapes such as a shrine but there has been little focus on what makes the lived experience at such a venue therapeutic or not. How does the 'encounter' in the 'therapeutic landscape' become therapeutic or transformative for the individual and/or their family?

The Muslim population in the UK is almost 3% of the total population. Health professionals in multicultural settings need to be able to adopt an approach which encourages a combination of world views – traditional and biomedical, in order to bring relief, and improve quality of life (Campion and Bhugra, 1997). Today, when people of different religions, beliefs, and backgrounds live together, it is important to understand and be aware of the basis of these beliefs and their impact on individuals, or there is a danger of mislabelling and/or misdiagnosis (Littlewood and Lipsedge, 1987 ; Bhugra and Bhui, 1999).

A clear gap has been identified as far as exploring the nature and process of mental healing at shrines is concerned and there remains a need to examine in greater detail the role of explanatory models in help-seeking and recovery from distress. In order to offer culturally relevant and appropriate care to a significant group of people, whether in Pakistan or the western world, health professionals require more understanding of individuals' explanations of how healing is perceived, sought and experienced.

CHAPTER 4: RESEARCH METHODOLOGY

INTRODUCTION

This chapter outlines the main aims of the study and the questions to be researched. Ethnography and qualitative research designs are explained and placed within the theoretical framework adopted. I then go on to describe the study setting, the Muslim shrine of Hazrat Abdullah Shah Asahabi; how permission to conduct the study and access to the site were obtained; how participants were selected and recruited; and the methods used to collect the data (semi-structured interviews and participant observation). Ethical and translation issues which arose during the research are also addressed. The processes of data analysis and data verification as well as the development of a theory to explain the data are described. Issues of reflexivity were crucial to developing a ‘true’ picture, free from bias, and remained a challenge throughout the research process.

METHODOLOGICAL CONSIDERATIONS IN QUALITATIVE DESIGNS

A review of studies from Pakistan and India in the area of shrines and mental healing indicates that the research in this area is frequently undertaken from a western psychiatric perspective. The description of the problems experienced by the participants have frequently been analysed against set psychiatric diagnostic criteria (DSM or ICD) used for classifying mental illness (Saeed et al., 2000 ; Raguram et al., 2002). These studies have focussed on measuring the prevalence of mental illness in a community or group or estimating the effectiveness of a healer or healing venue in terms of the clinical improvement of patients, using mental health rating scales and clinical interviews. The use of mental health screening tools, developed in the western world, to estimate mental health problems among people from different cultures and using

different languages is problematic in many ways (Rahman et al., 2003). Some of the issues involved include the linguistic and transcultural translations of the mental health tool used, cultural definitions of what is labelled normal or abnormal, differing idioms of distress and attitudes towards sickness/illness. These studies fail to offer phenomenological or *emic* perspectives.

I decided to take a qualitative approach to addressing the questions in the current research as qualitative inquiry allows exploration of the topic from the perspectives of those actually experiencing it. This method offers a greater degree of control to the participants in explaining their experience, perceptions, opinions, and ideas rather than imposing the researcher's frame of reference or world view. The experience of the participants in using a religious venue for healing makes them expert on how it works for them rather than seeing the mechanism from the point of view of practitioners who may generally follow a Eurocentric medical model perspective. Conducted in a naturalistic setting, qualitative research allows the capture of original social phenomena without inducing any manipulation or control to bias the findings. Semi-structured interviews and participant observation reduce potential bias by allowing in-depth exploration and immersion in personal perspectives and experience therefore limiting faulty cultural and social assumptions. The qualitative method offers a very appropriate method of inquiry when there is a dearth of literature on the topic of study (Fetterman, 1998).

QUALITATIVE APPROACH

Researchers have emphasised six significant characteristics that form part of the philosophy behind conducting qualitative research. These are: (1) a belief in multiple realities; (2) a commitment to identifying an approach to understanding that supports the phenomena studied; (3) a commitment to the participants viewpoint; (4) conducting the inquiry in a way that limits disruption of the natural context of the subject of interest; (5) the acknowledgement of the participation of the researcher in the research; and (6)

the conveyance of an understanding of the phenomena by reporting in a rich literary style including participant commentaries (Streubert and Carpenter, 1999). Those engaged in qualitative research share a belief that there is no single reality or truth as far as social phenomena are concerned. These realities can, therefore, be observed and understood in a naturalistic setting, without causing disruption to and/or manipulation of the setting.

Qualitative research may be multi-method in focus. It can involve the use and collection of a variety of empirical materials such as case studies, life stories, interviews and observations that describe routine and problematic moments and meaning in individuals lives (Denzin and Lincoln, 1994 ; Creswell, 2002). Some of the critical features of ethnographic research include social relationships, first hand information, naturalistic observation as interactive-reactive approaches, long term observation, participant observation, and the ethnographer as a research instrument (Creswell, 1998).

ANTHROPOLOGICAL/ ETHNOGRAPHIC RESEARCH DESIGN

Anthropology is synonymous with the term ethnography (Muecke, 1994 ; Streubert and Carpenter, 1999). Ethnography is a social science research method that relies heavily on up-close, personal experience and possible participation, not just observation, by researchers trained in the art of ethnography. Typical ethnographic research employs three kinds of data collection: interviews, observation, and documents.

"Ethnography literally means 'a portrait of a people.' An ethnography is a written description of a particular culture - the customs, beliefs, and behaviour-based on information collected through fieldwork" (Harris and Johnson, 2000). It describes a research design that is a form of social research, focusing on social phenomena, gathering detailed and in-depth data from a small number of participants and analysing the data by interpreting the meaning of human behaviour (Hodgson, 2000). It provides a comprehensive exploration of a

phenomenon which is anchored in a culture and explains both explicit and implicit aspects of the culture.

This research design derives its structure and principles from anthropology where the focus is on culture and how a culture develops, is modified, or destroyed. The understanding is often achieved by being part of the culture over a period of time and making conscious observations and recordings. The design focuses on holism and not certain specific aspects and on understanding human beings and the phenomenon as a whole. Spradley (1980) describes ethnography as a work of describing culture. Not only understanding the 'native's point of view' but learning from it should be the aim of the ethnographer (Streubert and Carpenter, 1999).

The *emic* perspective – the insider's or native's perspective of reality - is at the heart of ethnographic research. The insider's view of reality is instrumental to describing and accurately understanding a situation and/or behaviour. 'Native' perceptions may not conform to an objective reality but they reflect the true social reality as perceived by the participant and help the researcher understand why members of the social group do what they do (Fetterman, 1998).

As a health professional, I have noticed how limited health resources can contribute to pushing people to seek alternative ways of healing. However, there are also people with unlimited financial resources, and therefore more choices, who still prefer to attend shrines or other religious places in order to alleviate their distress. There are also those with very limited resources, who give up their work and income and seek healing at shrines – overall, this can cost more than consulting a neighbourhood doctor or health practitioner. I therefore embarked upon this project in order to gain a deeper understanding of insiders' perspectives, and the factors and processes that govern choices and decisions regarding help-seeking.

The current study has taken a qualitative research approach, mainly a descriptive ethnographic study. Ethnography provides the most suitable study design for the current research as the focus is to gain an in-depth understanding of insiders' or *emic* perspectives of how a problem brings people to a shrine for healing. It also allows exploration of how a problem is defined, explained, and experienced and what role the Shrine plays in addressing or resolving the problem. Kleinman's (1980) Explanatory Model [EM] guided the structure for data collection and semi-structured interviews, integrating Kleinman's 'eight questions', were used to elicit explanatory frameworks of illness among the participants. Participant observation was used to within the field over a period of three months. The field refers to a naturalistic setting where the social phenomenon is experienced and therefore can be observed first hand without causing any alteration. It is suggested that ethnographic researchers immerse themselves in the particular culture or social structure of a social group in order to achieve an in-depth understanding (Robson, 2002).

In this study the shrine of Hazrat Abdullah Shah Ashabi is the 'field'. The Shrine was a community in itself and people within that community, whether short term visitors or long term residents, related to a set of values and a shared belief system and participated in established activities.

As an ethnographic researcher, I did not depend only on interviews, but also was able to observe 'what was going on' (Dein, 2003, p.157). Participant observation helped in providing rich description and interpretations of cultural patterns. Participant observation in an ethnographic study gives the researcher an opportunity to access information from the *etic* perspective. The *etic* perspective is the "view of the outsider with interpretation" (Streubert and Carpenter, 1999 p. 148). Combining semi-structured interviewing with participant observation provides an *emic* view. Bhui and Bhugra (2002) acknowledge the importance of using participant observation with open-ended conversation, when exploring the explanatory models of patients. This method

is thought to embrace an authentic view of the patient's world, which is often lost if questions focus on making diagnoses and introducing a treatment. Dein (2003) points out that it may be "time consuming and expensive, but it is the only way to understand what our informants understand about sickness and how it informs their health-seeking actions" (2003, p. 157).

STUDY SETTING

This study was conducted at the Muslim shrine of Hazrat Abdullah Shah Asahabi (1520-1650 AD). It is claimed that Hazrat Abdullah Shah Asahabi is descended from the lineage of Hazrat Abdul Qadir Jilani (died 1166 AD) who was a well known Sufi saint and founder of the famous 'Qadaria' branch (silsila) of Sufis in Baghdad, in the 12th century (Ahmed, 2001 ; Dhaul, 2004 ; Government-of-Sindh, 2005).

The Shrine is located about 100 kilometres north east of Karachi, Pakistan, near the city of Thatta in the province of Sindh. Thatta has a population of about 1.1 million people and a literacy rate of 22.1 percent of the population (Pakistan Census report 1998). It is about 30 minutes walk from Thatta to the Shrine. People who visit or stay at the Shrine travel from all over Pakistan, but especially from Karachi. The Shrine is isolated from the local community and surrounded by a large cemetery. Access to the cemetery is through a gate and it therefore remains a separate and boundaried entity. Any vehicle wishing to enter the cemetery needs to pay a fee of five rupees at the gate. The distance from Thatta is such that visitors plan their journeys to the Shrine rather than just passing through. The back gate exit from the cemetery leads to a day time commercial area, largely deserted at night.



PICTURE 1: THE ENTRANCE TO THE SHRINE OF HAZRAT ABDULLAH SHAH ASAHABI

The Shrine is in the middle of the oldest and largest Muslim cemetery in the world, surrounded by a vast desert and more than a million tombs. People visit shrines as part of their religious belief system and paying respects to the saints is thought to bring prosperity, the fulfilment of wishes, and blessings on individuals as well as families (Gadit and Khalid, 2002). Some attendees however, come to the Shrine for specific purposes such as to seek healing for emotional or physical distress or conflicts within family and they stay at the Shrine for an unlimited period of time. These residents either come of their own volition or are brought by family members/friends, sometimes against their will. The decision to come to the Shrine may be directly related to a family's belief system or influenced by social networks and recommendation from previous attendees, other faith healers, or health professionals. In general, people believe that the spirit of the dead Saint, Hazrat Abdullah Shah Asahabi, will treat their ailments and assist in achieving physical and mental healing (Ahmed, 2001). According to popular belief, the Saint has reached an advanced spiritual position close to God as a result of having spent his entire life worshipping and serving humanity. This closeness to God gives him the power to

fulfil the wishes and desires of his followers. The Shrine is therefore well attended by people experiencing a range of physical, mental, spiritual, or social ailments and problems. Most of the time, either a family member (adult or child) or friend stays with the attendee or the attendee is left at the Shrine for healing and the family make weekly visits to monitor progress.



PICTURE II: VIEW FROM THE FRONT COMPOUND. THE MIDDLE SECTION HAS THE ENTRANCE TO THE SACRED DURGAH

During their stay, the attendees (and their carers) carry out daily prayers, read Qur'anic verses, socialise with others, and carry out activities such as cleaning the Shrine compound and preparing food for themselves. The majority of attendees come from lower socio-economic groups with low levels of literacy; however it is not unusual to also find those from more prosperous families and professional backgrounds. This profile of attendees resembles the overall population profile of Pakistan where about quarter of the country's population is below poverty line (The world fact book Office for National Statistics, 2008 ; The World Factbook, 2008).

There is no designated person at the Shrine who carries out healing rituals for or with attendees. It is expected that each individual will engage in their own prayers or healing strategies including reading Qur'anic verses, circumambulation (walking in circles around the grave of the Saint - an activity only for males), and singing religious poetry that praises Allah and the Prophet Muhammad (PBUH). Attendees staying at the Shrine do not pay for their stay but have to arrange for their meals and bedding. It is also common for visitors to the Shrine to distribute food, clothes, and gifts to short or long-term residents as a charitable gesture.

DESCRIPTION OF THE SHRINE

There are two big halls within the Shrine premises or compound; the first is a general residence for families and the second, a women only residence (children can stay with their mothers). The general residence is a rectangular shaped semi-concrete hall of about 50 feet in length and 30 feet wide, with a partial roof. This hall is located at the far left hand corner of the sacred *durgah*⁵. The women only hall is similar although one third of the size of general hall and located adjacent to the *durgah*. Both of the halls have a cement floor and open into a space where several other graves are located. The floor of the halls is bare except where people have laid floor mats [*chataaee*] or rugs to mark their own personal space. There is a gap of about one square foot between residents. A significant part of this space is covered with bedding, food, clothes, and utensils which people use during their stay.

⁵ *Durgah* - The most sacred place in the shrine where grave of the Saint is place. It is a small and congested room, brightly coloured and perfumed. The grave is covered with several colourful sheets of cloth [green and red with tinsels] and flowers. The room is also heavily perfumed with the burning incense sticks. There are big metallic trunks installed in the corners inviting donations from visitors.

PICTURE III: A VIEW OF THE WOMEN'S RESIDENCE HALL



PROCESS OF DATA COLLECTION

APPROACHING THE GATEKEEPERS

Shrines are generally considered to be part of the public domain. However, more recently the Auqaaf Department of the Ministry of Religious Affairs in Pakistan has been given responsibility for maintaining shrines and properties where devotional practices are carried out. This change has been brought in by the Govt. of Pakistan to deal with abuses at shrines and the practice of obtaining money for personal gain by self-proclaimed successors to the late saints. There are about 8-10 employees at the Shrine who carry out different tasks. Their duties include safeguarding the premises and valuables, supervising prayers and rituals, maintaining peace and harmony among the attendees and entertaining official visitors.

It is recognised that residents at the Shrine, especially women, are vulnerable and can be targeted by predators. Safeguarding personal valuables is the responsibility of the residents; however, the presence of the live-in caretakers

helps to maintain a safe environment. During special occasions, the Shrine is attended by thousands of people which increases the risk of violence, abuse and harassment as there is often an outpouring of emotion during such occasions. Additional police or security personnel are hired at these times to maintain control and peace.

I approached the Auqaaf Department through a professional colleague with my research proposal. The purpose, aims, and process were fully explained and all subsequent questions were addressed. A visit by my colleague was needed in order to discuss the aims and objectives of the study in person. Verbal agreement for the study was given in that meeting and I was asked to wait for the head office to grant final approval and permission in writing. After a number of follow up phone calls, a letter was received granting permission to undertake the study.

Upon receipt of written permission from the Department, I went to meet the manager of the Shrine personally to explain the purpose of the research. Additional documents such as translated copies of the consent form, interview guidelines, and demographic record form were also provided to the manager for review. He scanned it and assured me that total cooperation would be given and gave some suggestions about how to go about collecting the data. It is suggested that as an outside researcher, the likelihood of successfully accessing the research field is helped by entering negotiations and making use of connections, knowledge and courtesy (Lofland et al., 2006). Building rapport with the 'gatekeeper' in any government sector is a sensitive issue and needs skilful negotiation.

CRITERIA FOR RECRUITING PARTICIPANTS

I aimed to make contact with each of the attendees who came to the Shrine seeking help for a problem. It was anticipated that some attendees would be

emotionally distressed and therefore not willing or able to engage in the interview process. The approach to participant recruitment was therefore purposive following general guidelines. Those considered for participation were:

- Attendees staying at the Shrine for a minimum of three days who described the purpose of their visit as ‘seeking healing for a health problem’. I therefore included a variety of attendees such as those who were in the initial stages [within the first week], those who had been staying for a fortnight, and those who had been there for a month or more. I also sought out those who felt they were ‘ready to go home’ as their problem had been solved, partially solved or could not be solved;
- Carers, of those attendees who were too emotionally disturbed to participate themselves, were interviewed regarding their own perspectives on the experience of the one suffering. This was extremely important as the decision to seek healing at the Shrine was often taken or influenced by the whole family. The focus of the interview, in that case, was on understanding the explanatory model of the carer as decision-maker or executor of the decision made by the family. It was assumed that some attendees did not come to the Shrine willingly but had been forced;
- The minimum age requirement for the participant was set at 18 years old as this age gives a person adult legal status in Pakistan and s/he can avail citizen’s rights and responsibilities (can apply for an identity card, cast a vote, apply for a driving license etc.);
- A mixture of those who were visiting shrine for the first time, repeat visitors, and long term residents of the Shrine were included in the sample.

It was decided that attendees exhibiting serious intellectual or emotional impairment or disturbance (evidence of severe learning disability, psychosis or those under the influence of mood altering drugs) would not be included. It was recognised that participating in the research might create demands on those who were already emotionally disturbed or intellectually challenged, and

therefore cause further distress. For this reason they were excluded from the study.

APPROACHING THE ATTENDEES

Participation in this study was completely voluntary and without incentive or coercion. The nature of the research setting was such that the attendees were resting, praying, talking with their family/relatives, having their meals, or sleeping. It was not always very easy to recruit participants as it meant disturbing them from their activities and asking them to share stories which were sometimes painful to narrate thus possibly causing them additional distress. I therefore first approached potential participants and explained the purpose of the research project. I also asked them about their willingness to share their experience at the Shrine. I used a participant information sheet (see appendix 2 for the participant information sheet and consent form) to explain the purpose and nature of the study and assured participants that confidentiality would be maintained. For those who could not read, I read the sheet aloud and gave it to them to keep in case they wanted to consult their carer or relative before agreeing to participate in the study. It was emphasised that they could withdraw from the study at any time without giving any reason.

Many attendees, regardless of their eligibility for inclusion in the study questioned me about my background and my reason for being there. The most common assumption made was that the interview was for the purposes of publication in a national or local newspaper or magazine. Some people said that they felt wary of anybody with a cassette recorder or notebook as in the past; practices at the Shrine have been a target for ridicule by the media. On the other hand, some long-term residents at the Shrine hoped that the media would be interested in their stories so that they could be paid for their interview. I repeatedly explained that I was studying and researching a topic related to healing at the Shrine and therefore would like to listen to people's stories in order to gain an accurate understanding of this phenomenon.

Participants' demographics

A total of 26 attendees participated in this study. These included those seeking healing (14 females and 4 males), carers of those who were severely mentally distressed and therefore not be able to participate in the study themselves (6 females and 1 male), and a caretaker of the Shrine (male). The attendees came for a variety of problems, and all acknowledged the presence of illness, calling themselves '*mareez*' meaning patient. The age of the participants ranged from 18 to 80 years. The length of stay varied among the participants, from 4 days to 15 years. One participant, who was a caretaker, had worked there for over 20 years. There was a mixture of first time and repeat visitors, however, the participants were predominantly repeat visitors. For more details on the participants' demographics, please refer to appendix 3.

THE CONSENT FORM

The attendees who showed a willingness to participate in the study were asked to sign their name or put their thumb impression on the consent form [Urdu translation]. Requests to sign a consent form were usually greeted with suspicion. For those willing to participate in the study but not willing to sign the consent form, verbal consent was sought and tape recorded when appropriate. It was, however, apparent that some participants were uncomfortable in signing or putting their thumb print on the document and questioned whether their words alone were not adequate to assure me of their willingness to participate.

Although I explained that this was a measure to ensure that the participant had fully understood the task and was willing to participate, some attendees perceived it as a sign of distrust and refused to continue the process. There were some participants who laughed at the whole idea of signing the consent form and said that people who are not willing to participate in the study, would not talk if they did not want to, signing the form, therefore, seemed unnecessary. One woman expressed this by saying '*do you not trust me when I say that I am willing to participate, is it not enough?*' Situations like these gave rise to ethical

questions around consent and its value in the research process. At least 5 participants refused to sign the consent form and those who allowed their interview to be audio-tape recorded were asked to give their consent verbally on tape. One client refused to participate in the study altogether when she was asked to sign a consent form. She became very suspicious and defensive and despite assurances of confidentiality and privacy she refused to take part.

This situation demanded flexibility and modification in documentation to make the research process culturally appropriate and acceptable to those participating. What seemed most acceptable to the participants was that I read the consent form out loud and they confirmed their willingness verbally prior to the start of the interview.

DATA COLLECTION METHODS

The major data collection methods in ethnographic research are participant observation and in-depth interviews. The aim of these in qualitative research is to give respondents the opportunity to fully describe their experience in their own words in order to ensure that the data reflects their experience, understanding, and ideas.

INTERVIEWS

To gain an understanding of the explanatory model of attendees at the Shrine, a semi-structured interview guideline was developed. According to Rose (1994), a semi-structured interview allows the interviewer to “focus on issues of particular importance to the research question, to probe and clarify comments made by the informant and to use prior knowledge to help him or her in this process” (p. 24). It allows informants the freedom to tell their stories and express their feelings directly rather than be constrained by predetermined questions.

It is suggested that the interviewer have an initial plan of topics or questions but be guided by the respondent in determining sequence in the course of interview (Robson, 1993). The interview guideline, used in this research, integrated eight questions from Kleinman (1980) aiming to elicit the participant's EM of his or her problem. These were: what do you call the problem; what do you think has caused the problem; why do you think it started when it did; what do you think the sickness does and how does it work; how severe is the sickness; will it have a short or long course; what kind of treatment do you think the patient should receive and what are the most important results you hope he/she receives from this treatment; what are the chief problems the sickness has caused; and what do you fear most about the sickness?

Dein (2003) suggests that explanatory models are not straightforward and treatment choice is not determined solely by explanatory models, but is primarily governed by social and political factors. This therefore necessitated adding further questions to the interview guideline that focused on exploring the meaning, value and appraisal among attendees, in the context of seeking support and help for ill-health. Broad opening questions were added to the eight questions suggested by Kleinman in order to explore the meaning and importance of place and its role in the healing process. The interview questions (see appendix 4) attempted to capture a holistic picture of attendees' experience.

As I progressed with interviews, the nature of the question guide changed. Although basic questions remained the same, I felt more able to explore in depth how the attendees linked their behaviour to their explanations and their reasoning. I was also able to ask particular questions which were raised through my participant observations and the answers from the attendees also led me to possible locations and times to make further observations. The fairly loose structured interview guide (Fielding, 1994 ; Rose, 1994 ; Robson, 2002) allowed

freedom to the participants to express what they wanted to about the topic whilst at the same time giving me some control on the areas I wanted to cover.

Many participants asked that all the questions should be read to them before they agreed to participate. Those who could read were provided with a copy. I also gathered basic demographic data about the participants. As the interviews progressed, the nature of the interview questions changed as I tried to clarify or explore themes that had been raised by participants in earlier interviews. May (1991) points out that this may bring more structure to an interview but not in a way that restricts participants' freedom in how they address the topic.

According to Streubert & Carpenter (1999), researchers often do not aim for a specific number of interviews but continue with interviews until saturation in the data is achieved, i.e. a point in the data collection phase when key themes are consistently repeated and no new information is being gathered. The authors argue that the term 'saturation' in the data can only be used for a specific point in time and it may not be applicable in the same situation at a different time. I continued to interview participants until a point was reached where the data appeared 'saturated', that is, the themes and information emerging from the interviews largely repeated what had gone before and nothing 'new' appeared to be added to the data already collected.

Tape recording

Just over a quarter of those willing to be interviewed refused audio recording. The reasons for this, given both by male and females, included fears around their views and personal situation being heard and identified by others, considering it against the moral values governing shrines and religious healing venues and the 'veiling' of the voice for women, who believed that their voices must not be heard by any males outside their own families. Some people also believed that religious matters should not be talked about with anybody else as

it is a private and personal communication between a person and the higher being. While many participants agreed to have their interviews recorded after lengthy explanation, others did not. Those who agreed insisted that we sit far from public places to avoid disapproving glances coming our way. Those who refused tape recording permitted the taking of notes by a colleague during the interview.

I carried a small tape recorder with me at all times with additional batteries, in order to avoid equipment failure in the field (Easton et al., 2000). At the beginning of each interview, I tested the recording with some general comments recorded on the tape and played it back, so that the participants could observe and be informed about the process.

Location and conduct of the interviews

There was no separate room available to conduct the interviews. Some attendees preferred sitting in their usual place within the Shrine premises - on the bare floor or floor mat, whereas others agreed to move to peripheral parts of the Shrine to achieve more privacy and quiet. The attendees who were staying with carers were interviewed in their presence or on their own according to their preference. At times other attendees came and sat around the participants during the interview and started sharing their own thoughts and opinions and the researcher had to intervene in order to provide maximum privacy and least distraction. Although, it often appeared that each of them knew the story of the other and the participants did not seem to mind if they heard them again.

It was made clear at the beginning that the interview could be stopped at any time if the participant felt unable to continue. There were times when participants started crying when discussing emotionally distressing events or circumstances. In those instances, the interviews were discontinued for a short period before proceeding further. In interviews where the participants refused

audio recording, contemporaneous notes were taken by a colleague accompanying me. Soon after completion of the interview, I reviewed these notes and made additions for later transcription where necessary. The total duration of the interviews was approximately 40 minutes. A token of appreciation in the form of a *duppatta* (scarf) for females and shawl for males was offered to the participants. These items are considered sacred, culturally appropriate, and relevant to the religious atmosphere of the Shrine and communicate respect for the recipient.

Being culturally competent and congruent were significant factors that influenced the process of data collection. Being from the same culture, part of the same religious community, speaking the local language, and having understanding of the values, beliefs and cultural and social structures of people in Pakistan worked in my favour and assisted me in gaining acceptance from the group. I used myself as a research tool and approached the attendees with respect and positive regard, regardless of their age, level of hygiene, health, or socioeconomic status. I also kept in mind that despite being from the same culture, I was still an outsider as I was there for the purpose of research and not living there because of ill-health. This might have been perceived by some as threatening or as an intrusion. In addition, I may have represented to them somebody who did not fit their image or stereotype of a traditional Pakistani woman. I made special efforts to provide people more space and time to adjust to my presence. For example, upon arrival at the residence hall of the Shrine, I went to the women, greeted them, shook hands with them, and then just sat on the floor with my colleague for a few minutes. Mostly, during this time, the new attendees became aware of my presence and took feedback about me from others who had seen or met me before. Some covered themselves from head to toe and went to sleep, clearly indicating an unwillingness to interact.

All possible measures were taken to make the process of data collection as non-threatening and positive as possible, taking into account all ethical

considerations. I remained aware and highly sensitive to the social environment and demonstrated respect for the Shrine and attendee's belief systems at all times. This included wearing suitable dress, using the local language and appropriate body gestures, and paying respect to rituals carried out during my presence at the Shrine.

Participant observation

Participant observation is a commonly chosen method in ethnographic research. A key feature of this method is that the researcher or an observer seeks to become a kind of member of the group. This may involve "not only a physical presence but also entry into their social and symbolic world through learning their social conventions and habits, their use of language and non-verbal communications" (Robson, 2002 p.314). It is also described as a process in which "an investigator establishes and sustains a many sided and situationally appropriate relationship with a human association in its natural setting for the purpose of developing a social scientific understanding of that association" (Lofland et al., 2006 p. 17).

Participant observation provides first-hand details concerning social phenomena and insight into the lives of people and the way they describe and experience their problems, in a naturalistic setting. There are often interesting similarities, differences, and contradictions in how people think they behave and their actual behaviour in any given situation. This sort of observational data provides a good opportunity for triangulation of the data, gathered by different methods (Hammersley and Atkinson, 1983). Lofland et al. (2006) suggest that participant observation is most fruitful when the question, topic or situation is physically located somewhere, as observation at that specific physical location will yield the richest data. The primary data gathered is the observation by the observer of what is going on around him/her. In this way, the observer becomes the research tool or instrument, and requires personal skills and sensitivity (Robson, 2002). An increased level of closeness with the culture under study

may raise possible bias and subjectivity. However, Manis and Meltzer (1967) argue that the researcher's first hand experience of socialising in a naturalistic setting enhances the scientific value of the data gathered and the way it is interpreted (cited in Robson, 2002).

Different terms describing degree of involvement have been used to illustrate the role of the researcher in the observation process. These include: 1) the complete participant - in this case the researcher conceals his or her purpose of being in the field, which often causes major ethical concerns; 2) the participant as observer - the researcher acknowledges interest in researching by participating in all activities. It is also called 'going native' in the literature and there are debates about the level of involvement with the activity and the potential to lose sight of the real reason for being in the field; 3) the marginal participant - where the predominant activity is observation but the researcher may be involved in some activities passively; and 4) the complete observer - where the focus is on systematic observation, and no interaction between the researcher and participants takes place (Robson, 2002).

For the purpose of this research I assumed role of a 'Marginal Participant (MP)' (Robson, 2002). This role required me to declare my position as an observer and interviewer from the very beginning. By assuming the role of MP, although I predominantly observed the social, religious, and interpersonal processes at the Shrine, I was also able to participate in some general group activities at my own discretion. The role allowed me the flexibility to ask questions while observing and exploring further where appropriate. Maintaining this dual role is not easy and often depends upon the group's nature and how acceptable they find the presence of the interviewer. Age, gender, ethnic origin, and use of language can play a role in how acceptable this is (Robson, 2002). Although I wanted to achieve an emic perspective during this research project, at the same time I did not wish to get personally involved in the fundamental experiences of

the women including experiences of trance. This was because I did not want to give up what Pfleiderer (2006) calls the ‘protective status of the observer’.

Being an observer at the Shrine helped in making my face familiar to the attendees and therefore was crucial in developing rapport especially with the female attendees. This approach allowed me to remain detached from the social phenomena in terms of ‘not being native’ but also enabled me to participate in some activities and explore issues that at times needed clarification. It also aided in gaining an in-depth understanding of the social processes taking place in the Shrine. These observations were used as cues during semi-structured interviews to help explore symbolic meanings and the impact on attendees.

I carried out observation at different sections of the Shrine at different times. Certain times of the day appeared more important, such as prayer times, meal times, and when family members or friends visited, mostly afternoons. Similarly, some days were considered holier than others, for example *nochandi*⁶, and *Urs*⁷, when religious ceremonies continued for a long period of time and great numbers of people visited the Shrine.

I did not choose to take a role as ‘participant as observer’ or ‘become a complete participant’ as the research focused on deep-seated religious and cultural values, beliefs and practices in a sacred venue which could not be implemented without true intent. There were also personal risks involved in entering a highly emotionally charged arena where maintaining boundaries and focussing on research objectives was sometimes difficult. Becoming a complete observer might have provided a personal or emotional detachment from the social

⁶*Nochandi* - The night of first lunar Thursday each month (begins Thursday evening and ends early morning on Friday and is considered a significant decision day at the Shrine)

⁷ *Urs* - The birthday of the late Saint

phenomena and therefore reduced risk of bias. However, I could not assume the role of a complete participant or complete observer as I was interviewing individual attendees or their carers to obtain detailed accounts of their perspectives. Being a complete observer in this situation may have limited possibilities for exploring the practices or rituals which were carried out as part of seeking healing. I therefore tried to combine a certain observational detachment with participation in particular activities which I found comfortable and acceptable.

Intensive interviewing is the term used to describe a process that “encompasses both ordinary conversation and listening as it occurs naturally during the course of social interactions and semi-structured interviewing involving the use of an interview guide” (Lofland et al., 2006 p.17). These authors emphasise that participant observation always involves the intertwining of looking and listening, participating and asking, and some of that listening and asking may be identical to intensive interviewing. This is an important way to proceed for a researcher interested in the day-to-day social experience of a particular setting and is crucial to gaining understanding of social process in action.

Very usefully, another category of participants emerged as a result of my interaction with attendees during participant observations. These were the attendees who were sitting around either observing or carrying out healing rituals or just talking to each other. I directed my questions about rituals I observed towards them, presenting myself as a ‘selective incompetent’ (Lofland et al., 2006). Most of them happily explained the situation and meaning attached to behaviours or rules governing those behaviours. These conversations often took place alongside actual ‘events’ and I was able to obtain a ‘running commentary’. Once again, some of the commentators agreed to the tape-recording of these conversations whilst others allowed note-taking. I refer to these participants in the text as ‘informal participants’ (INF) and use narratives obtained from them in the next chapter (Data analysis).

The data collected from ‘informal participants’ was treated similarly to that collected from the formal research participants. Consent was given by the informal participants verbally and in most instances, they allowed me to tape record our conversation or take notes. These informal conversations were transcribed and have been used in the data analysis alongside the data collected in the formal interviews. To identify data from informal participants I have used the code INF. As informal participants were selected and approached for very brief interactions often as particular events were taking place, it was not possible to go through the written consent form with them. However, the purpose of the research and the process of data collection were explained to them. All the informal participants were willing to take part. Murphy and Dingwall (2007) emphasise that the practice of obtaining prior informed consent in written contractual form was developed in relation to clinical trials. For ethnographic research, the process needs to be negotiated and renegotiated.

Field notes and memos

Observations made in the field are often recorded in the form of diaries, logs, and memos and analysed as part of the data. Field notes add value to participant observations (Lofland and Lofland, 1984). Some of the methods suggested by the authors include mental notes, jotted notes, and full field notes covering mechanisms, contents, and style.

The data gathered through observation was written down in a field note book in the form of notes, memos, comments and diagrams while I was physically present at the Shrine. I also provided an additional notebook to the colleague accompanying me to record any observations she had made while I was busy interviewing a participant. I also found it very useful to record my thoughts into a hand held tape recorder when I had few private moments or while having lunch. At times, I found it easy to just talk into the tape recorder using mental notes which I gathered during my presence at the Shrine (Lofland and Lofland, 1984). The data from these notes and memos were filed in the form of observation logs. These observation logs were shared with the research

supervisors and emerging themes were discussed and explored in the field on an ongoing basis.

ETHICAL ISSUES

The proposal for this study was reviewed and approved by the Health Studies Ethics Sub-Committee of Middlesex University, London (see appendix 5 for the approval letter). After receiving approval from the Ethics committee, the proposal was registered with the postgraduate research office. As it was the first study of its kind to be done at a shrine, permission was also sought from the necessary gatekeepers, including the Auqaaf Department of the Ministry of Religious Affairs in Pakistan, and the manager of the Shrine, to conduct participant observation as well as interviews with attendees at the Shrine. The proposal for the study and all necessary documents were provided in advance to all the relevant departments for their review. I also encouraged the key personnel at the Shrine to raise any questions or concerns they had, prior to and throughout the data collection process.

All necessary steps were taken to safeguard the confidentiality of participants and the information they provided. The consent form clearly explained how the data would be anonymised and used for research purposes only. The security of the data was given the utmost priority. Information on locally available health centres and hospitals was kept available in case the need arose. I provided information related to medicines, their use and side effects to those participants who requested it, however, I deliberately avoided labelling any condition as 'disease' or 'illness' and behaviour as a 'symptom' and did not impose treatment views from any particular standpoint. At times this was difficult as I witnessed cases of epilepsy, toxic goitre, and hypertension and although I conveyed my concerns to the attendees about a possible physical cause for their problem, the choice over whether to seek medical help was theirs.

DATA TRANSLATION

All the semi-structured interviews were conducted and transcribed in Urdu and then translated into English for analysis. About 10% of the total transcripts were back translated by a bilingual health professional to check and assure the accuracy of the translation.

It is advised that when translating research data from the native language into English, the first translator should have proficiency in the English language but should have the target language as his/her mother tongue (Beverly Weidmer, 1994). In addition, the aim should be to carry out conceptual translation rather than literal or word-to-word translation, jargon should be avoided and sentences kept clear, simple and concise. I translated the Urdu transcripts into English using an authentic 'Feroz Sons - Urdu to English dictionary' that is published locally in Karachi and used widely in other countries including the UK. The authenticity of the translated text was also checked on randomly selected Urdu transcripts (2 excerpts of 5 hand written pages) using an independent translator, who was bilingual and had a health and similar cultural background. The second stage in this process was back-translation in which the selected translated English transcripts were back-translated into the primary language i.e. Urdu. The two versions of the Urdu scripts were then compared to see the variation in terms used and the concepts and meanings. The emphasis in the back-translation is on conceptual and cultural equivalence and not linguistic equivalence. Conceptual equivalence refers to "the absence of differences in meaning and content between two versions" (Beverly Weidmer, 1994 p. 1227). The process of back translation improves the reliability and validity of research. Comparison of the translations showed that they were accurate and revealed conceptual uniformity although some linguistic difference.

DATA VERIFICATION PROCESS

Reliability and validity are key issues in ensuring quality in qualitative analysis (Mason, 2003). These terms refer to the process of describing whether the conclusions drawn from the data are credible, defensible, justified and able to stand up to alternative explanations (Miles and Huberman, 1994). Lincoln and Guba (1985) substitute the word 'trustworthiness' for validity when applied to qualitative research. They also use the terms credibility, transferability, dependability and confirmability, which they suggest are more applicable in qualitative research design. Lacey & Luff (2001) suggest that the process of quality assurance in qualitative analysis is concerned with the validity of researcher's interpretation from the data gathered. The emphasis is not to present 'truth', as it is widely accepted that multiple realities exist. The goal is to achieve a fair and accurate representation of the data collected.

Mays and Pope (2000) consider respondents' validity or participants' recognition of themes, as a significantly important aspect of qualitative analysis. Hammersley and Atkinson (1983) suggest that the crucial test for the validity of the researcher's interpretation is whether the actors, whose beliefs and behaviour they purport to represent, can recognise the validity of those accounts. It was clear that opportunities to follow up attendees participating in the research in person or through correspondence would be limited. The reasons for this included: a) uncertainty around the time of their departure from the Shrine; b) their wish to remain anonymous and un-contactable; c) low literacy levels among the participants; and d) an inefficient postal system. Taking into account the limited opportunity to follow up individual research participants, I used a group approach to data verification. Five transcripts – transcribed and translated were sent to the following: a) research supervisors, with expertise in transcultural research and mental health; b) a health professional who was native and had a background in mental health; and c) an independent health professional with a mental health background and exposure to the culture where the research was carried out. These experts reviewed the

transcripts line by line and sent back a list of emerging themes to me. I carried out a similar line by line thematic analysis of those five transcripts independently and compared this with those themes identified by the experts. This process led to a researcher triangulation in identifying a list of emerging themes.

During my last visit to the Shrine, I gathered the attendees present there and after explaining the purpose of data verification, asked if they would participate in the activity. Four to five women sat in a circle with me showing interest in the process and permission to audio record the process was sought and gained. The researcher went over the identified themes one by one and encouraged the attendees to express their agreement, disagreement or make additional comments. Gradually other attendees also joined the group and some began to share their own stories in line with the identified theme being discussed. For example, one theme which highlighted that the attendees who returned home without 'permission' from the Saint experienced a worsening of symptoms generated discussion. It was suggested that this was due to the power and strength which is gained by the evil possession as a result of physical distance from the Shrine and the Saint's lack of control over the situation. Listening to this theme, one attendee shared her story describing how she suffered from severe emotional ailments as a consequence of leaving the Shrine prematurely and how consequently the whole treatment cycle was prolonged.

All themes identified were recognised by the group of attendees as relevant and significant and they particularly identified those that were applicable to their own life situations, although most of them had not participated in the original research. I also took the opportunity to highlight and address some inconsistencies in the data. For instance some research participants suggested that the use of medications during their treatment at the Shrine could interfere with the healing process whereas others continued to use their medications for physical ailments. The responses from the group highlighted ambiguities in

their own belief systems. They suggested that there were no particular restrictions on using medication or any other treatment whilst seeking healing at the Shrine, however, if an individual relied on medication for healing, it could be interpreted as a failure to completely surrender to the Saint and his healing regime.

DATA ANALYSIS AND THEORISING

According to Berkowitz (1997), qualitative analysis provides “ways of discerning, examining, comparing, and contrasting, and interpreting meaningful patterns or themes” (p. 1). The overall aim of qualitative data analysis is to produce a detailed and systematic recording of the themes and issues addressed in the interviews and to link the themes and interviews together using a reasonably exhaustive category system (Burnard, 1991). The process of analysis and interpretation involves disciplined examination, creative insight, and careful attention to the purposes of the research study (Genzuk, 2003) and is the most crucial step in any qualitative research. The focus is the development of analytical categories (Mays and Pope, 1995), using inductive or deductive approaches.

The data from the current study comprised of interview transcripts, field notes, informal conversations, and observation logs. All the data was considered when attempting a qualitative analysis. The whole research process was supervised throughout. 10% of the transcribed interviews and logs of the field notes were shared with the supervisors and three independent analyses were done and initial codes were identified. Questions were added to the semi-structured interview guide, as a result, in order to broaden the scope of the data collection and to gain deeper understanding of the meaning the participants held for the rituals and processes at the Shrine. The data was collected and read until a level of saturation was reached

The completed transcribed data was loaded onto a computerised software tool NUD*IST (Non-numerical Unstructured Data Indexing Searching Theorising) that supports the development of hierarchical categories of coding (Ritchie and Lewis, 2003). As the data collected was large in volume, the computerised programme was very useful in organising and coding the data systematically. It also allowed the retrieval of data based on a key word search mechanism.

Coding is used as a means of generating concepts from and within the data. Although the coding is used for the process of analysis, it should not be considered analysis in itself (Coffey and Atkinson, 1996). Miles and Huberman (1994) suggest that coding allows the rich material to be combined and differentiated so that further reflections can be made on the data by the researcher. The raw data in the current research, both from the interviews and participant observation was coded line by line. The coded data was then organised under the broad categories. Categories are defined as “being about something or relating to some particular topic or theme” (Coffey and Atkinson, 1996 p. 27). It is suggested that the broad categories under which data be sorted can be guided by a theoretical framework or it can be ‘observer identified’ (Hammersley and Atkinson, 1983 ; Weitzman, 1999). In the present research I used Kleinman’s (1980) eight questions for eliciting attendees’ EMs as broad categories. The coding of the data, line by line, also assisted in identifying and recognising key themes and patterns that emerged which were not directly related to Kleinman’s EM but clearly highlighted the role and meaning of place. The codes were examined, grouped together based on common properties or elements and developed into an additional 23 categories of varying sizes. The importance of a ‘category’ is that it consists of all the coded data that pertains to a concept (Robson, 2002).

The coded data under each category was then analysed as a complete category and/or concept to identify the themes or patterns contained within and I considered how each category related with other categories or concepts. Several

sub-categories became visible through this process and began to interact with other data. As suggested, I used short memos and notes continually while analysing the data to try and see the emerging themes in relation to those present in other categories (Weitzman, 1999). For example, the data under the category of 'causes of problem' when further analysed, brought to light sub-categories such as social, emotional, physical, supernatural, or other causes. This cross examination also led to more complex themes surfacing that played a significant role in determining an individual's explanatory model for seeking help for the problem they experienced and perceptions about healing at the Shrine. This process helps us to understand the social world of the participant more clearly, rather than uncovering an absolute truth (Lacey and Luff, 2001 p. 7). It is suggested that the important analytic work is in "establishing and thinking about such linkages, not in the mundane processes of coding" (Coffey and Atkinson, 1996 p. 27).

The movement from coding to interpreting involves playing with the data. Dey (1993) suggests that after developing the codes and categories, the aim for the researcher at this stage is to 'refine' or 'refocus' the analysis. This can be done by reorganising data around the categories or concepts under which the codes are placed or by retrieving the categories, splitting them into subcategories and splicing and linking them together (p. 139). For the current research, I assigned multiple codes to the data where appropriate and this allowed me to look at the same 'bit' of the data under a different category therefore enabling me to see it in a different light or context.

Analysis and interpretation are considered conceptually separate processes. According to Genzruk (2003), the analysis process begins with assembling the raw materials and getting an overview of the entire process. It is then essential to bring order to the data, organising what is there into patterns, categories, and basic descriptive units. It includes consideration of words, tone, context, non-verbal aspects, internal consistency, frequency, and big ideas. Interpretation

however, provides insight into the meaning and significance of the analysis, “explaining descriptive patterns, and looking for relationships and linkages among descriptive dimensions” (Genzuk, 2003 p.9).

Following the categorisation of the data and analysis of the categories, I shifted my focus to the ‘recontextualisation’ of the data (Tesch, 1990, cited in Dey, 1994). I carried out what Dey describes as a ‘splicing of categories’ (p. 139). The categories and subcategories were put together in order to derive greater integration, sharper focus and to see how the pieces of the jigsaw fit together to make a pattern. Constantly referring to a wide variety of literature helped me with the ‘splicing’ process. It helped me look at data from different angles, thus revealing an overall dimension. Contrasting data in terms of what was most talked about and was present in abundance versus what was not mentioned in a direct way also brought interesting insights. I used diagrams to further establish the connection between the categories and continued doing this until a coherent picture began to emerge.

Coffey and Atkinson (1996) emphasise that the analysis of qualitative data does not stop at the coding and retrieval of data fragments, it needs to go beyond to find the meaning. They call this process ‘generalising and theorising’ (p. 139). They highlight that our ideas influence the sort of data we collect, how we interpret them, and how we organise them. Our ideas are informed by either the participants themselves, or existing literature concerning the research or the context from which the participants come. For the current research, the theorising I did was based upon interviews and observational data I collected as well as my understanding of the social context of the participants. I was also informed by my experience as a mental health nurse working in a Pakistani health care context and as a woman coming from a patriarchal society where the oppression of women is institutionalised in social, health and welfare systems and internalised by the general population.

I employed a process of moving from an examination of small details within the data to consideration of the 'bigger picture', asking myself what were the underlying meanings for participants and the hidden processes taking place. This included processes that were not recognised by the participants themselves. Having developed my own hypothesis of what was taking place at the Shrine; I went back to the data to test the veracity of my theorising to see if the evidence was available to support or challenge my interpretation. This process further refined the development of the theory.

In this way I telescoped back and forth between the micro-processes and a wider overview until I arrived at a position where the theory that emerged appeared to 'fit' with and be supported by the data that was there as well as that which was not. The theory was set out in diagrammatic form (see Chapter 6 - Discussion) in order to make it as clear as possible. For a summary of the data analysis in the form of a figure, please see Appendix 6.

ISSUES OF REFLEXIVITY

Schutz (1970) encourages researchers to make their beliefs explicit before embarking on the research process (cited in Streubert & Carpenter, 1999). This is essential as it makes clear to the researcher her/his own assumptions, judgments, prejudices, and beliefs which may colour the process and interpretation of the data. In this way research is promoted which is open, honest, and non-judgemental.

It was important for me to make my own position explicit as a researcher. I was born and brought up in Pakistan, and belong to a sect of Islam. I am a South Asian female and have worked as a health care professional (mental health nurse) with people in hospitals and in the community. My professional training was strongly influenced by western bio-medical models of distress and illness and my professional competence was measured against these standards. Whilst

training, it was necessary for me to evaluate behaviour in the light of Western classification systems (DSM or ICD). However, during my work as a nurse, I witnessed complex and intricate processes that guided people's decision making when distressed or suffering illness. While allopathic practitioners are generally contacted for physical health related problems, large numbers of people seek alternative healing strategies for problems which I would label as mental health problems. Religious venues, especially mosques, shrines and holy places play a significant role in assisting healing in Pakistan.

Living all my life in an environment that is structured around religion and religious activities, I have always perceived this positively and have witnessed how religious coping can assist a person to find meaning and explanation when faced with a crisis. Coping strategies like personal and group prayers, congregational activities involving social support and a sense of belonging and having a purpose in one's life, all provide direction. However, I have been cynical about those who choose an approach to religious practice where rituals are carried out in order to maintain status or position in society without actually understanding the essence behind the practice. Similarly, seeking religious healing when the locus of control is placed externally and when one chooses not to reflect on one's own behaviour, social factors affecting the situation, not taking responsibility for moving forward and remaining passive in dealing with problems are things that I perceive to be damaging. Nonetheless, I have heard the stories of people who, when being at a shrine have experienced healing and recovery.

For me, being from the same culture and sharing common cultural beliefs could have been both instrumental as well as restrictive. On the one hand it provided grounds to relate with those who were researched and helped to develop the rapport necessary to elicit rich data. However, on the other hand, it could colour my interpretation of the events and symbolic meanings and introduce bias. In order to avoid this, I used a reflexive approach; clarifying my assumptions

repeatedly and seeking supervision from a clinical psychologist from a Pakistani cultural and research background (PhD). I also received debriefing from a colleague from a mental health background, audio-taped my thoughts, opinions and ideas and exchanged thoughts with the research supervisors for their guidance and cross checking. It was a journey where my personal beliefs, values and identity as a Muslim woman were constantly questioned and challenged. Whether in the Shrine or during travel to and from the Shrine using public transport, questions were constantly asked about the purpose of my presence and my study. People generally struggled with the whole concept of conducting research and how it related to the traditional role of women in Pakistan.

HOW I WAS PERCEIVED

My repeated journeys between Karachi and the Shrine made me a familiar face on local transport. While some drivers reserved seats for me, others suggested other shrines or healers which may be useful in finding healing for my ‘problem’ (I was assumed to be a person seeking healing at the Shrine). In a culture and environment where public transport is not usually used by females without a male escort, my travel arrangements invited curious glances, stares, and at times harassment from males.

I made special efforts to dress according to local norms and show respect to the Shrine setting. With time, I became familiar with some individuals who introduced me to other attendees. Being a female gave me easier access to the female residence hall. However, there were those who disapproved of my presence and discouraged other women from participating. My presence at the Shrine as an unescorted female (not escorted by a male), not wearing a veil, and talking to male attendees, raised concerns, suspicions, and questions from some. While some people wondered whether I represented the media doing a story about the Shrine, others showed resentment, anger, and hostility. These negative feelings reflected their disapproval of seeing a woman in a non-

traditional role, and they communicated their belief that talking about religious healing was inappropriate. Having a female colleague with me at all times was helpful however and gave me a greater air of respectability than if I had been alone.

The attendees who were long term residents at the Shrine and who were from very poor socio-economic backgrounds perceived my presence in terms of resources. They asked me questions about what I had in my bag, if I had any food, if I could buy them food, sweets or give them money to support their stay at the Shrine. While it was difficult for me to witness such levels of poverty and deprivation, it was equally important for me to draw clear boundaries around the purpose of my visit and not encourage any dependency or raise expectations, which I could not meet.

SAFETY ISSUES

I travelled to Pakistan for the purpose of data collection from the attendees at the Shrine. When in Pakistan, I commuted to the Shrine on a daily basis, from Karachi to Thatta, using public transport. As a female, making intercity trips using public transport is unusual and generally considered unsafe. Although I am native to Pakistani culture, it was still applicable. I am aware that it is considered inappropriate and invites assumptions about 'immoral character' in people's minds. It was therefore very important that I always travelled with someone else and made most of my visits during the day time. The times when I stayed overnight, I remained accompanied at all times. Although I interacted freely with women at the Shrine, with males my interactions remained focused on the interviews and to the point. This is one reason why I had a smaller number of male research participants. It was important that I limit the chances for unwanted attention and harassment from men and be taken seriously in a society where gender segregation is a norm and measure of honour.

CONCLUSION

This chapter has outlined the research process and the reasons for choosing this particular design and approach to the subject under study. The data collection phase was challenging in a number of ways including explaining the purpose of the study and recruiting potential participants and in stepping outside gender stereotypical behaviour in Pakistan as a female researcher.

Semi-structured interviews in combination with participant observation allowed evidence of the micro processes of everyday life at the Shrine to be collected and the therapeutic nature of the landscape to be explored. The details observed helped identify the participants' world view and how they connected their 'problem', in their particular social context, with the Saint's instructions and treatment and how they subsequently perceived healing.

The data was thoroughly analysed and attempts made to verify the findings with those living the experience of the Shrine. I was then able to generate hypotheses and theorise as to the nature of the therapeutic processes taking place at the Shrine. I was required to continually question myself and reflect upon my own interaction with attendees and with the Shrine environment. This proved to be a constant personal challenge.

The results from the research generated a unique set of knowledge and theory in relation to pathways to help-seeking among distressed populations and the role of the Shrine as a therapeutic landscape. The recommendations from the study should open up avenues for further research and investigation in the area of alternative approaches and its impact on health and well-being in a Pakistani setting as well as broadening the perspectives of established health professionals in multicultural societies.

CHAPTER 5: DATA ANALYSIS AND RESULTS

INTRODUCTION

These findings bring together my observations, interactions with people visiting the Shrine and quotes from the attendees who participated in the research process. Many times, the informal conversations arose from observations I made about everyday living experiences at the Shrine.

The major themes emerging from the data were: the attendees' explanatory model of sickness, including the nature and manifestation of the problem; the social context of participants; the Shrine and the healing process, highlighting the belief systems of the attendees, the relationship with the Saint as healer and the Shrine as a sacred place of healing, and what were believed to be the specific elements of the treatment process; the daily routine, rituals and difficulties of everyday life in the Shrine community; and the pathways or routes that attendees took to reach the Shrine and choose this form of healing. A summary of the major themes is presented in table format in appendix 8 showing the relative strength of each theme in terms of its appearance in the interview transcripts.

Each research participant has been assigned a pseudonym to protect their identity. The other coding that has been used is for those participating as informal participants during intensive interviewing. INF refers to Informal, F/FC, M/MC refers to Female/Female carer, Male/Male carer, MCT refers to Male care taker and the digits refer to the numerical identity assigned to each encounter/observation.

ATTENDEES' EXPLANATORY MODEL OF SICKNESS

EXPLAINING THE NATURE OF THE PROBLEM

Most of the attendees struggled with naming the problem that had brought them to the Shrine. Instead they described a variety of symptoms that they suffered from.

The problem was often described in terms of physical or emotional symptoms by a great majority of the attendees. For others, however, the problem was located externally and manifested itself in the form of a series of negatively appraised events and personal or family misfortune. At times it was difficult to separate the impact of symptoms from the explanation. The cause and effects were used interchangeably to describe the 'problem'.

Symptoms manifested within the person

The problems that were described were a mixture of physical, emotional, and/or cognitive. Some of the physical symptoms experienced included lack of energy, heaviness in the head, lack of sleep, restlessness, breathing difficulties, incontinence, headaches, stuttering, fatigue, fits, strange bodily sensations (excessive heat), and pains/aches in muscles, dizziness, and paralysis.

For example, SABIHA described the physical symptoms she experienced:

'I don't know – I just feel a sudden heaviness in my body, I start to feel very tired and my head hurts. It feels like someone is pulling my legs and arms apart from my body.'

NASR described her symptoms in graphic terms:

‘I had real bad ‘ghabrahat⁸, restlessness and it felt like my heart would sink. My whole body was burning – it felt like I was on fire. I couldn’t get out of bed, wasn’t able to take care of anything.’

SUBHA described the pain she experienced and physical changes too:

‘I am telling you that I was in a condition that I lost all the ability to think or understand. I was pleading to Allah that please grant me a bit more life until my children are little older and can take care of themselves. It was such a powerful shock that I had such a severe pain in half of my head that I used to hit my head against the wall.’

Some described their problems in the context of emotional symptoms. These included feelings of lifelessness, anger outbursts, a detached or unconcerned attitude towards family members, lack of interest, violence, seeing or responding to unusual things (voices, images of snake or hands), ‘uncontrollable rage’, ‘doing things repeatedly’, cutting self, low self esteem, worthlessness, sadness and suicidal thoughts. Some attendees also described experiencing difficulty in concentrating on their work (home or paid work), distractibility, diminished thinking ability and loss of awareness of the environment.

SABIHA, a sufferer and a carer described her daughter’s distress:

‘...she would bang her head on a wall in our house, would sit for hours crying, and would stop eating and drinking.’

⁸ Ghabrahat - has been described as: fear, nervousness, apprehensiveness, anguish etc. It also includes physical symptoms like perspiration, loose-motions, trembling, and sinking heart

SEEMA experienced a total lack of energy:

‘I can’t get out of bed. My whole body feels like it does not have any energy in it. I lie almost unconsciously the whole day... I can’t function.’

One carer (INF-F-34) described the problem as changes in her son’s behaviour and it had been suggested to her that he was possessed:

‘He (son) doesn’t do anything. Has just packed up his work and is sitting at home. It has been two and half years and he is not doing anything... has isolated himself completely and doesn’t go out or interact with anybody. Lately he has started to talk a bit because we have been bringing lots of healers to the house to have him checked and diagnosed. Some people say he is possessed, others indicated magic.’

SUBHA felt frightened and terrified:

‘...just sat there in silence. My mental state was like I couldn’t take any noise at all. If a spoon fell, then also I would be so scared. My heart would fill with terror that someone would kill me. I used to see faces, horrible faces, shadows here and there, everywhere....’

In addition, over-involvement in religious rituals, challenging authority and disinhibited behaviours such as disrobing or highly sexualised speech content were also seen as signs of a ‘problem’. Behaviours that were not socially acceptable or sanctioned, such as self harming, sexualised talk, and physical aggression by women were difficult for attendees and their carers to understand. Social adversity or social and personal stresses were not necessarily considered to be possible causes of the behaviour. Being ‘possessed’ or being ‘made’ to do things by someone else, were deemed more plausible explanations.

Manifestation of the problem in external events

For some attendees, there were no obvious physical or emotional symptoms. They recognised they had a problem when appraising life events which they perceived negatively. A series of unfortunate events such as loss of job, failure of a business, loss of valuables and accidents were all seen as a result of possession by an evil spirit or magic spells being cast upon them.

The Shrine helped AKEELA to make sense of negative events in her life:

‘It was different everyday. After I gave birth to my children, they started to get affected. When they were about three weeks old, they started to have fits; at times fire would erupt in some part of the house and also continued to lose things from home. I never believed in supernatural remedies and magical power etc... when I started coming here, then I learnt that it was a completely different matter.’

MUHIB linked a number of unfortunate events:

‘I think I still have some magic on me and its effects can be seen. Like when I got a job with the police force, I suffered a serious accident. Now I have developed cataracts in both eyes and I can’t see things clearly.’

These misfortunes were usually labelled at the time of occurrence as bad luck. It was only later when a number of negative events were considered together that the ‘problem’ was recognised. When other family members also started to experience problems in their lives, this reinforced or confirmed ideas the participants had, that the problem was caused by magic or possession and that this was now spreading to others.

Magic or possession named as the problem

Magic or possession by an evil spirit was named by the majority of the participants as the problem that they suffered from rather than the symptoms alone. The nature of the problem and its cause were synonymous.

WARI described her problem in this way:

‘I have been possessed... by jinn and ghost ... and I have come here to get rid of them.’

MOOMAL believed she had been possessed since childhood but this had not become apparent until after she gave birth. That was when it (*jinn*) manifested itself in the form of severe pain:

‘It gave me such immense pain. I felt it (*jinn*) was sitting on my chest and I could not breath, it smothered my throat and I could not speak a single word. My eyes were open and I could see the whole world, but could not express anything.’

One mother (KAUSER) only recognised the supernatural nature of her daughter’s problem after the failure of medical treatment:

‘She (*daughter*) has pain in her lower stomach during her menstruation. We went to a doctor for this problem and sought treatment for three months but there was no relief at all. So we have now come here to see if there is any benefit... may be her problem is related to something different...we have this feeling that it is due to magic.’

Frequently if diagnostic tests and consultations with medical experts did not bring relief from symptoms or a believable explanation of the problem then the nature of problem was considered to be supernatural and not medically related.

MOOMAL described a long search for a plausible medical explanation for her symptoms before being convinced that her problem was supernatural:

‘For a long time, about 15-20 years, I have had treatment from doctors. I went through all the diagnostic tests, in J hospital, one diagnostic test cost Rs. 70,000 (£700) took all sort of pills and injections, had some intravenous drips also but it did not relieve my suffering’

There was sometimes either a gradual shift in the explanation of the problem as different solutions were tried or parallel explanations were entertained at the same time. For many it was religious healers or experience at shrines that provided them with a name and explanation for their problem. Many attendees once engaged in ‘treatment’ at the Shrine, seemed prepared to live with uncertainty about its duration or success, and waited sometimes for many years without complaint.

Sometimes the nature of the problem was vague or not understood by the attendees or their carers. The hope was that the Saint would know and reveal the cause. This was so for ZARA:

‘It is ill health and I don’t know what has caused it. It may be related to magic but I don’t know. *Baaba* (the Saint) knows these things better and will tell me when appropriate.’

The nature of the problem was described in terms of deteriorating health and pain as well as in terms of loss and misfortune. Possession and magic as well as being recognised as causes of problems were often named as the problem itself.

EXPLAINING THE CAUSE OF THE PROBLEM

As well as being described as the nature of the problem, magic and possession by jinn and evil spirits were major themes that emerged repeatedly during the

interviews. They were considered to be the main causes of problems in a person's life and led to attendees seeking help at shrines.

Magic and possession were perceived to have different causes. Magic spells were inflicted by others and resulted from other people's jealousy, envy and wishing to do others harm. Possession by evil, however, was something perceived to be caused by accidents, or sinful/immoral behaviours. The participants described stepping onto unknown geographical boundaries, disrespecting sacred places (*e.g. urinating in a graveyard*), women going to places that were deserted and uninhabited, not veiling themselves or adopting immodest ways of living by embracing Western ways (*e.g. wearing western clothes, watching foreign TV channels, socialising with the opposite gender*), or breaking social and behavioural taboos as reasons why possession occurred. Some people suggested that magic spells could make a person vulnerable to possession by jinn or evil spirits.

Magic and supernatural possession

Magic spells were often delivered by *aalims* (learned men) who had been contracted by others to cause harm. A customised magic potion was often used which came in various forms such as a powder to be mixed with food, a doll or image of the person to be affected to be hidden under the bed, pins and needles to be hidden in the closet and so on. The attendees who described themselves as victims of magic believed that it was due to jealousy, revenge or retaliation. This could be provoked by the rejection of a marriage proposal, when one became wealthy or prosperous, or had a happy life.

The attendees also shared the firm belief that jinn and evil spirits existed. They were perceived to be part of the supernatural world and to have greater power than human beings. They could work for or against human beings depending upon their relationship with them. The attendees described the ability of the jinn/evil spirit to:

- Become visible or invisible as they desired;
- Impose control over a person's physical, psychological and social health;
- Cause pain, distress and conflict between the person and their family;
- Take on different personas in order to tempt human beings into doing things against their will;
- Possess a human being's mind and body and remain dormant for years before surfacing ;
- Give extra physical strength to human beings to fight off others who may try to control them. For example, a surprising amount of strength displayed by a person not usually known for this brought suspicions about their possible possession.

Some participants were able to pinpoint those responsible for the magic. SUBHA identified the culprits:

‘It started slowly and then...my mind was completely finished... all these so called religious scholars, they enchant people on instruction (*from other people*).’

SEEMA described a different source of magic:

‘Their family members used to visit us sometimes and bring some food items. I think with these food items, they fed me something that had a reading⁹ on it.’

FEHMIDA thought she was a victim of jealousy and her life had been severely affected:

‘...it has been 8 years now. I have changed so much, I am almost finished now. When a child is very intelligent the other relatives start to feel

⁹ Magical reading - Belief that magic spell is cast through a potion of food on which verses were read to make it harmful

jealous because they don't want their relatives to be prosperous and successful in their lives. This jealousy made them do things (*cast magic spells*) to disable a person completely. My dad's brother and his wife made our life very difficult.'

SUBHA further added:

'This is just enmity. People can't see others happy. It is jealousy and envy.'

For NASR the problem was related to her relatives' interest in their land:

'My husband is a landowner. We have a good deal of land and a big house too. My sister-in-law wants this land to be theirs. They have tried their best to spoil relationships between my husband and me so that they can get all the property. When I started having children, then they got so angry that they wanted to destroy me.'

Many people had no idea how their problems were caused until during their *hazri*¹⁰, they were shown the faces of those who may have been involved in causing their ill health but also that they have to maintain secrecy as instructed by the Saint. SABEEHA tried to guess who might be responsible for her son's condition:

'...he (son) takes his aunt's name during *hazri* suggesting that it is her magic spell that has caused him this distress – sometimes his evil spirits talk in both male as well as female voices. Who knows how many of them are inside him?' (SABEEHA)

The attendees also discussed how their illness and problems were related to a failure to follow religious rituals and practices carefully and being selfish and

¹⁰ *Hazri* - A process in which there was an interaction between the Saint and the evil spirits.

cruel to others. Changing social values (e.g. mixed gender socialising, expectations of comfort and luxury in life etc.) and/or loss of religious and spiritual values were perceived to weaken the inner soul of a person thus making him or her vulnerable to possession:

‘...to tell you the truth, it is all the result of our own acts in this world. Each person has been given a level of power from Allah but we don’t use that and get into the material world...If we recite our Qur’an every day and look for instruction about ways of living, then we won’t be in a state where we are today. We don’t wish people well; don’t have love for each other then how can we be blessed.’ (SUBHA)

MANZOOR, the caretaker, agreed with this idea:

‘There is no recital of the Qur’an or prayers and no respect for others (in ordinary life of young women). So what happens is that when these girls mature, all the ghosts, jinn come to attack them....’

Another attendee INF-F-30 shared her views on how possession by jinn and evil spirits could be prevented:

‘Those who spend time praising Allah, learning spiritual knowledge, sacrificing their lives for the greater good and developing a close connection with Allah cannot be dominated by the devil or a jinn....’

It was suggested that the jinn and evil spirits ordinarily lived in deserted places such as suburban areas, graveyards and under very tall trees and that they were invisible to the human eye.

This was described by WARI:

‘When I was young, we used to play under a mango tree. We used to throw mango seeds at the tree and also sometimes urinate under the tree. I was so young I didn’t know that there may be some jinn residing there and they will be upset with that.’

SABIHA, a carer, explained why and how possession could occur:

‘Some dirty souls wander about and when they see someone with good characteristics like beautiful hair, eyes, body or nature... When these people make mistakes like walking in the graveyard when they are impure [*menstruating*] or throwing stones at trees, they can be possessed

She thought that entering a graveyard may have led to her own daughter’s possession:

‘...there was a graveyard near the hostel. As one of the walls was broken, a lot of children played in that area...who knows what might have happened there.’

Certain times of day such as sunset, late night and early hours of the morning were thought to be popular with jinn. However, nobody suggested that there might have been predators preying on young and vulnerable women that made these times inherently unsafe for them. Some attendees also voiced their opinion that evil spirits and jinn lurked around celebrations to prey on weak targets. It was suggested that beautiful women could become targets during these celebrations as they used perfumes and make up to look attractive. Drawing attention to one’s physical appearance could attract an evil spirit, something that only seemed to apply to women.

There were a few who thought that possession could pass from mothers to children during childbirth. These influences once transferred or acquired, then remained dormant for many years before becoming active again at significant times in their life, for example, marriage, child birth or starting a job:

‘I was told that my ex-wife had some (*evil*) influences which affected S (*daughter*) also when she was in her womb. The influence has now shown itself to the world....’ (FAZAL)

There was a perception that those who worked too hard could lose their physical, emotional, or moral strength and as a result become targets for evil spirits. A sister accompanying her brother, RAFIQUE, to the Shrine attributed the cause of his problems to working too hard:

‘he works very hard and that is the reason he has become very weak... he was very young when he started working...about ten years old when he started labour work in the shop where they made plastic bags.’

Whatever the explanation, the attendees and carers were constantly trying to understand what had actually caused the problem and what they had done to make themselves vulnerable to possession or evil.

It was interesting that although the participants frequently described social stressors such as poverty, domestic violence, and unemployment, they did not consider social adversity or circumstances to have or contributed to their ill health. This was the case for SAREENA who did not connect traumatic life events to her suffering:

‘There were other problems also which started to occur in the household; my husband actually killed another man by slashing his throat and police are after him still. He used to beat me badly too. He (*healer*) prescribed a lot of amulets for me but my suffering increased with time.’

The attendees sometimes visualised the possession and described clearly how they saw the evil force possessing them. RANA described the evil in the form of a snake:

‘...yes I can see it clearly. It is a big black snake. I can see it crawling along and it feels like it has gripped my eyes, my nose, and my complete brain. It feels like it has a strong grip on my heart and my liver. Its eyes take over my eyes, I can’t see anything, and I see things differently, a little shrunken and distorted.’

Sometimes the symptoms arrived suddenly and were described as ‘a mountain erupting in my head’ or ‘as if I was pushed into a well’. One woman described graphically how the jinn grabbed her with ‘his’ hands, which were thick, powerful, and strong and kept her restrained.

TARA gave a dramatic description of the onset of symptoms:

‘My heart was fluttering. I felt severe restlessness. I felt like someone has grabbed my heart with their bare hand and was squeezing it. And I was crying and telling my family I will die. My colour was also changing and everybody was like shocked thinking what to do. When they came near me to comfort me, I told them to stay away, or I will kill them, I was completely out of control.’

The words used by some attendees to describe the jinn and possession, such as ‘big hands gripping me’ and ‘evil entering into me’ (INF-F-35) could be interpreted as suggestive of sexual abuse. However, none of the participants mentioned this directly or even hinted that such abuse had taken place. The whole topic of abuse, sexual abuse in particular, is taboo in Pakistan. I therefore avoided asking explicit questions about experiences of abuse as it could have resulted in me being asked to leave the Shrine.

MUHIB described the jinn being dissolved in his blood and circulating in his body trying to find a place to live. As the jinn moved within his body, the pain moved with it:

‘You see this devil has my body completely. It is circulating in my body like blood. When they checked my blood they saw that I was weak, which is what I was saying, that this is due to the possession.’

The presence of jinn could have devastating effects:

‘It disturbed my whole life. Sometimes it gripped my heart, sometimes my head, my limbs, and sometimes tongue.’ (WARI)

They imagined these evil spirits circulating in the body and finally being physically eliminated through vomiting, diarrhoea, sweat, or blood. One woman saw tooth decay as a sign of evil inhabiting her mouth; for another, epileptic fits were caused by a snake crawling in the body; and backache was blamed on an evil spirit grasping the spinal cord. It was difficult for them to see how operations, medications, or drips would free them from the grasp of evil.

Interestingly, the male caretaker (MANZOOR) of the Shrine expressed his belief that magic was used as an excuse for women to leave their homes and come and spend time in the Shrine so that they did not have to take on (or possibly to get respite from) household responsibilities. He strongly believed that it was a way of escape for those wanting an easy life or who wanted to look for sexual pleasure outside the home. He condemned women leaving their homes and living on their own at the Shrine where strange men and women spent time under the same roof and where there was a chance of finding men and starting a new life. He believed that women should just get on with life rather than making demands for change.

The enmity and jealousy of others, often close relatives, was often identified as the reason for the magic. Other attendees seemed to focus on their own personal failure, frequently in religious terms, as the cause. For others, especially women, possession could result from entering an unsafe place, venturing from their usual environment or because they had drawn attention to themselves and their physical appearance and so were being punished. Many attendees described the jinn and its effect in graphic and dramatic terms.

EXPLAINING THE IMPACT OF THE PROBLEM

The impact of the problem was seen in the light of the overall well-being of the affected person and their relationship with family members and was often considered to be socially devastating in the wider community.

The attendee's behaviours were often seen as embarrassing and inappropriate. FAZAL (*a father and a carer*) described his daughter's behaviour and how it made him feel:

'If there was a young man standing nearby, she would laugh (*considered immoral and a sexually provocative act*) and seeing this, my heart would bleed. Many a time this happens, I see her looking at a man and I feel so upset and go and move her face away to the other side. I prayed a lot and now Allah has granted some improvement....'

The behaviour caused conflicts and arguments in the immediate and extended family, brought family tensions to the surface, and challenged societal and family norms which had been maintained for generations. For many, the resulting behaviours risked family respect and honour. SAIMA's mother explained her embarrassment:

'My daughter was so lively before, so full of life and cracked jokes all the time. Since the spell, she has lost sense of her clothing or hair, or food. She would throw whatever came in front of her, beat others and swore at everybody. When her father took her to college, there also she started swearing at everybody and all were shocked about what has happened to her.'

RANA's mother described the effects of her daughter's behaviour on the whole family:

'Just imagine if an adolescent girl takes her clothes off in front of her father and brothers and says these shameful things. She forgot who she was and who outsiders are. She said that I am going to the males outside...Her brothers were crying and weeping loudly that what has happened to our sister. She was so distressed, would scream so loud that the whole neighbourhood was shaken up.'

Often conflicts within the family and an inability to fulfil role demands such as housekeeper or breadwinner were blamed on the interference of evil spirits. At times when the afflicted person's behaviour caused a problem for the family, the use of physical force and violence by family members in response was common and considered acceptable. It was believed that it was the evil spirit that was the target of the violence and not the afflicted family member.

Some families did not agree with the attendee's explanation of possession for the ill health but nevertheless tried to accommodate the belief by taking the sufferer to and from the Shrine, whereas, others put restrictions in place to discourage the affected person from going to the Shrine. In the majority of instances, a decision to stay at the Shrine by an attendee was supported by the family and one or more family members became full time carers and stayed with the person and the whole family visited at the weekends.

The overall impact of the problem was largely discussed in terms of its social impact. The impact could be huge if family respect and honour were called into question by highly inappropriate behaviour and the transgression of social norms.

EXPLAINING THE SEVERITY OF THE PROBLEM

The problems experienced were considered to be severe by attendees and/or their carer. It caused them to feel 'unwell' and behave in ways that could not be managed at home. Many also shared a strong belief that serious magic spells could also lead to death if immediate measures were not taken to address the problem.

FARHANA described how lost she felt:

'I did not know anything around me, if someone pushed me over, I would fall but not necessarily know what happened. I would get on a bus to go somewhere and then would not know where to get off. I would leave

home to go to my sister's place and would end up getting off somewhere I have no idea about ...If someone gave me some food, I would eat, otherwise I would be sitting on the road with no idea as to where I was.'

WARI was completely incapacitated:

'...it has disabled me completely. I felt so unwell that I can't go anywhere or participate in anything. I didn't even manage to change my clothes. As far as household chores are concerned, I can't even take off the clothes from the washing line, I have to ask somebody to do that.'

Many attendees put themselves at risk of exploitation by others as they began to lose their ability to keep themselves safe, began to beg on the streets, or behaved in public in such a way that made them vulnerable. Initially the families perceived these actions as 'dramatic', or 'attention seeking but as time passed, they realised that there was a possibility that the person was possessed. SAIMA's mother was horrified with her daughter's condition and began to shadow her everywhere she went:

'...she started showing some disturbed signs. She started beating everybody and throwing stuff around and when she went to the toilet; she came out without her trousers.'

Some attendees discussed how being possessed made them into a completely different person. They became anxious, and lost confidence in their ability to carry out tasks. For one, the problem was so serious she considered death a possibility:

'My ability to think and understand was completely diminished. We went and sought help from religious healers; they said that someone has cast a very strong black magic on me. They (faith healer) said... either I will become completely crazy or I will die.' (SUBHA)

Some neglected their self care, did not wash nor change their clothes for weeks, and wandered around on the streets or in shrines. One mother (Rana's) described her distress at her daughter's condition and care needs:

'I run after her (*28 years old daughter*) with food, water, clean clothes telling her please eat something, please drink something. When she has her periods, I change her, give her a bath.'

Some of the participants reluctantly admitted feeling suicidal and experienced extreme guilt for even entertaining these thoughts. MOADIT said

'I was so scared ... had thoughts about killing myself.'

One young woman expressed her distress by self harming and suicidal attempts, which shocked her mother and her family. Her mother (SABIHA) described her reaction:

'We had no knowledge about this cutting business, this we have learnt recently. She used to bang her head, once she also took tablets. It is completely shocking'.

RANA said:

'I beat myself, I beat myself with stones/rocks, I have cut myself, I have taken tablets but nothing helped'

It was actual or potential harm to self that often made the family realise that help was needed to avoid the potentially fatal consequences of the magic spell. The harmful consequences could be rapid:

'Sometimes this magical spell is very strong and set with timing, like the person will die within 1 hour of consuming the food or drink water. By the time help is sought, the person is dead already. People think that the

death is due to abdomen problems or some other physical illness but in reality, the matter is really different.’ (MOADIT)

Interestingly some attendees who sought healing at the Shrine had problems which had clear medical causes. For example, a young woman who had severe pain associated with her menstrual cycle, a young girl who suffered from epilepsy and had seizures especially when exposed to noise and light, and a young woman who suffered from a severe learning disability. However, the physical causes were not always recognised by the attendee or their carer as was demonstrated in the following exchange between a mother and the researcher:

FP: ‘Many women experience some level of pain and discomfort during their menstrual periods don’t they?’

Kauser: ‘No, nobody feels pain or any discomfort during their periods. I have always had them and had carried on with all the household chores. I have eight children and 9 grandchildren. Although I don’t get menstrual period anymore but I have never had any pain.’

Supernaturally caused illness was thought to be contagious and those helping the attendee were most vulnerable to catching it. RANA explained how the effects of her own possession had spread to her brother:

‘One of my brothers, he worked really hard for me. He took me to all the doctors and whoever can help, but there was no benefit. After a few years, he also started getting ill, he had multiple accidents, his stresses increased, every other day there is a loss or a worry. He said to my mother that ‘this thing (*evil spirit*) is interfering in my life also; I can’t remain involved any more’.

It was suggested that I avoided shaking hands with those experiencing *hazri* (*perceived to be possessed*) because if the evil spirit was angry, it may also have affected me.

Attendees described how the problem produced a number of often disabling effects and could potentially be fatal. Possession could also cause self harm and suicide. The social consequences could be equally devastating and inappropriate behaviour put attendees at risk of harm. Although a few had recognisable physical health problems, they attributed them to supernatural causes.

EXPLAINING HOPES FOR TREATMENT

The attendees hoped for healing in terms of improvement in physical symptoms and elimination of undesirable or socially embarrassing behaviours. For some, the hope was to gain control over chronic illnesses with little or no medication. SADA felt that being at the Shrine had removed the need for medication:

‘...when I come here (*the Shrine*), my medications work more effectively. When I pray to the *Baaba*, the *Baaba* then prays to Allah and that is the reason medications work... I am prescribed to take one tablet a day for my high BP, but since I have come here, I have not taken that (*it had been two weeks already*).’

Due to limited finances SADA also wanted the Saint to cure her illness so that she did not need to take expensive medications:

‘I am not going to take any medicines now and this is my aim. These medicines give more of an adverse effect than helping my health. Why spending so much money on these medicines when all they do is to make me feel worse. It is good that my sons earn enough to run the household and also take care of my medical needs otherwise...’

Hope was an essential part of attendees’ belief in the Shrine:

‘I really hope that it happens. Some people have scared me that it takes a very long time and sometimes people don’t get well at all...but we are

really hoping that *Baaba* will fix the problem by next *Nochandi* (first Thursday of the lunar month) and we will go home.’ (WARI’s daughter)

And

‘I hope this restlessness, *ghabrahat*, blackouts, feelings of being unwell will go away and peace and joy will fill my heart. There are other things also like other wishes, which I hope to achieve but I don’t want to talk about it.’ (ZARA)

Some attendees regarded physical/medical treatments as ineffective because they could not ‘remove the problem from its root’. They may control symptoms but not effect a cure. This was discussed by ZARA:

‘No I have decided that I am not going back on medications. They have limited use and they are not the answer. I will be going home after the Shrine and get on with my life and if my illness returns then I will wait for instruction from *Baaba*. Let’s hope this God’s beloved will heal me.’

Healing was often described in terms of being ‘taken care of’. While some focused on the disappearance of symptoms, others focused on the experience of peace, increased energy levels and the ability to participate in expected social roles and maintain harmonious relationships. SUBHA described the level of peace achieved and hoped this would be maintained at home:

‘At home we sleep on thick foam mattresses with fans and everything and still don’t feel that peace. Here we sleep on the concrete floor with a thin sheet covering us. There are also lots of mosquitoes, and other insects but the peace this place and living here gives, makes it worthwhile. Yes when we will go home after staying here, then we will find that peace at home also.’

WARI looked forward to resuming social roles once she was healed at the Shrine:

‘I will feel energy in my body, will feel like doing some work, will be able to do my prayers, I will feel like going out of the house and meeting others – I have not been out to others homes for a long time.’

Some attendees stated that they had become better people as they now took more interest in prayers and their connection with Allah. Those with previous experience of seeking healing at the Shrine endorsed the idea that a person could be completely cured and re-integrated into society.

A complete transformation and recovery were believed to be achievable. SUBHA reflected on the transformation in her own condition:

‘It (*appeared to be a panic attack*) would come anytime. For example when I am ready to go to market, it will come and I would fall, drenched in cold sweat, feel terror in my heart. And then after a while I will be alright again... Slowly it increased and the time came when I was in bed the whole time, completely disabled. Now it has been more than a month here (*at the Shrine*), I neither have pain nor fever. The attacks have also gone and I am completely normal now.’

Attendees at the Shrine were interviewed after different lengths of stay. While some had been there for 5 days, others had been there for the last 15 years. For many of them, the perceived improvements in their condition range from ‘30-90%’. NASR measured her improvement:

‘The frequency of my headaches has gone down. Now when I talk to someone for long periods of time, then it slowly starts but otherwise it is not coming. I think I am one third better and the remaining two thirds is left.’

The strength of belief in the magic or possession was such that although doctors had explained the limitations of treatment for a condition, the Saint was believed to be capable of treating any problem if the sufferer or their family

continued prayers and pleading. The oral tradition of describing tales of healing miracles performed by the Saint raised attendees' expectations that everything could be fixed or treated if the Saint interceded with Allah on their behalf. The power held by the Saint defied any logic or limitation. It matched the illogicality of the magic and possession theories.

SHARIFA described her 10 years old daughter's epilepsy and her belief that the Saint was curing the condition:

'She gets fits in her whole body; she loses consciousness and falls to the floor... she can fall anywhere, she cannot see if it is market or shrine or home. She can have a fit anywhere and everywhere. In the beginning she had those fits frequently but now thanks to *Baaba* her fits are under control.'

This belief in the power of the Saint was also expressed by FARHANA:

'I would have died – I would have died a long time ago because I could not swallow a single piece of bread even. All my thanks are to the *Baaba* (*the Saint*) for making me so much better.'

The attendees hoped to gain control over physical symptoms, reduce their reliance on medication and address the root cause of a problem. Hope and faith in the Saint's ability to heal were essential parts of the belief system and narrative of attendees at the Shrine. Complete recovery from a problem was considered a genuine possibility even after many years of suffering.

THE SOCIAL CONTEXT OF THE PROBLEM

The social context of the attendee played a very important role in explaining the development and continuation of the problem. It also provided insight into how the problem was perceived and appraised.

FAMILIAL EXPECTATIONS OF DOMESTIC VIOLENCE

The family played a crucial role in the lives of attendees, in many ways, including contributing to the development of problems, managing the problem, seeking help and providing practical and emotional support while the attendee was 'under treatment'.

The family situations described by the attendees highlighted the existing patriarchal system where women experienced oppression and were dominated by male members of their family. Often older women in the family joined with the men to impose authority and power over younger females. These experiences appeared to have contributed to the mental distress of attendees. FARHANA, like many, had an arranged marriage at a very young age and had experienced significant domestic violence and abuse:

‘She (*mother in law*), used to be really horrible to me... she would beat me up after restraining me. I was only 15 years old when I got married, that was not the age for marrying and taking responsibility. She sold everything from my dowry and took all the money.’

Nasr also experienced domestic violence everyday after she married. She felt it was unfair and returned to her own family. After only a few weeks, she was sent back to her husband by her parents, she felt that she had no choice but to continue to accept her fate and pray for mercy from Allah:

‘We have these traditions that after marriage, girls should not leave their homes. They can leave their homes in the form of funerals only otherwise it is a major shame for the family. What could I do if he remarried; I would have no roof over my head’.

After marriage, women were expected to fit in with the standards and practices at their husband's house. Some struggled when family values were different:

‘I read the Qur'an and *na'at* (*songs to praise the Prophet - PBUH*) all the time, and my husband didn't like it at all and therefore he beat me up, my

body was full of bruises and marks. He would not give me anything to eat or drink for days...He threw me out of the house with no money or clothes.' (FARHANA)

Domestic violence was generally accepted, especially if males were tense or stressed, women often justified their behaviour. This was true for SHAHEEDA (SAIMA's mother):

'... my husband...would get upset and beat others. There was a lot of tension everywhere. In my absence, if he asks her (SAIMA) to do some tasks, she would refuse straight away. Mothers can tolerate that attitude, fathers cannot, and so he would beat her...he beat her so badly....'

Women had little power over their lives. Even when her husband was unfaithful and gambled away their money, FARHANA could do nothing to improve her situation:

'He [*husband*] was of an older age too and was fooling around with other women, stayed in hotels etc. and put a lot of money on gambling. As we had children, I started to do some labour work to feed my children and that enraged her (*mother in law*) further. She snatched my children from me, took all my stuff, and threw me out of the house.'

While MANZOOR (*the male caretaker*) acknowledged the prevalence of domestic violence among women attendees at the Shrine, he was unsympathetic and could not see the connection between adverse social situations and the problem itself, rather he suggested that it was the women who needed to improve:

'In my view, middle aged women come here with domestic problems. They get beaten up at home and come here...why does magic affect women only? The actual problem is lack of work... In the early days women worked very hard.... Now, they don't work. (*They*) have their

meals and then go to bed. A thousand thoughts get into her head and then they come here with so called magic and jinn possession’

Only a few men were interviewed for the study. All mentioned not being able to fulfil their expected familial and social roles but were either reluctant to go into detail or justified their limitations by focusing on how debilitating the effects of magic and possession were and how it stopped them carrying out their expected responsibilities. Some of them talked about comments being made to them about opting for an easy life and not taking financial responsibility for their families.

MOADIT felt that it is generally perceived that those living at the Shrine were looking for an easy option:

‘Some people see this as I have left home, my family and my kids and living my life here. They think that I am here because I don’t have to work and I get free food etc. and that I enjoy this lifestyle. My heart cries loudly when I hear people saying that’

It was not uncommon for female research participants to have suffered repeated domestic violence. They clearly felt a lack of control over their lives and powerless to change their situation. The few male participants seemed to find it difficult to talk about their failure to live up to familial expectations but expressed distress that others would think they were opting out of their responsibilities.

SOCIAL STIGMA AND EXCLUSION

Many attendees said that in their community, people who were thought to be possessed or under magic spells were seen negatively. People feared being ‘contaminated’ by them and they were therefore often excluded from social gatherings and celebrations. At times, the magic itself was thought to negatively

affect the opinions and attitudes of others. This was particularly painful for RIZWANA:

‘Even the children in the (*extended*) family hate us. They turn their faces if they see us. ...although they all are literate and are working in good positions but nobody wants to have any relationship with us. This is all due to my sister and since she has started this magic spell, the attitude of the whole community has changed towards us.’

The attendees felt that their distress and suffering was not understood by others. As a result they became isolated from the extended family and neighbours.

The same behaviours which were labelled as crazy, odd, and weird at home were more likely to be accepted in the Shrine setting where the prevailing belief was that evil forces were causing the problems. SEEMA described the differences in attitude towards her at home and at the Shrine. Some neighbours thought she was ‘crazy’:

‘There are all kinds of people. Some do understand it and others don’t. Some people call me crazy and don’t interact much with my family or me.’

People at the Shrine, however, were more understanding:

‘They all feel my pain and understand what I am going through. They see how much pain I bear due to *hazri* and what has become of me due to this long illness. They understand ‘asar’ (*influence*) and its effects more than ones outside the Shrine.’

This was echoed by RANA’s mother:

‘Outside, people say she is crazy, she is embarrassing, and people are reluctant to come to us, whereas here, people are good. They understand

what she is going through and they try and help her in ways they can. They pray for her and encourage her when she is not well.'

Some carers felt that the unpredictability of the behaviour of the afflicted family member was what made it difficult to survive outside the Shrine. It required them to either hide the person in the house to save the family from embarrassment or to give them medications which kept them sedated so that peace could be maintained at home. MOADIT felt not understood by the 'outsiders':

'...the pain I am bearing cannot be understood by the outsiders. If they were given this pain, then only they could comprehend what it is like to leave your parents, your family and your children and spend your life at the Shrine.'

Attendees were often stigmatised because of their problem and regularly experienced exclusion from community and social events. They felt little understood and isolated. This was in stark contrast to their experience at the shrine where they did not have to worry about maintaining secrecy, justify their inability to work, or rely on medications to keep control of their behaviours. It was a place where they felt understood and where unusual behaviours were accepted and even expected.

POVERTY AND SOCIAL ADVERSITY

Experience of poverty and social problems were commonly described by participants. A majority of attendees came from lower socio-economic groups and struggled to meet the basic needs of the family. For TARA and her family, there were perpetual worries:

'...there are always worries, sometimes about money, sometimes about other people... I feel restless and frustrated all the time...'

In another example, one 4 years old girl J, who lived at the Shrine with her mother was told by her mother to ask people for money, food, and clothing because she (mother) was not well and could not work. She was taught to 'get things from others because we cannot have our own' (OBS23)

The women from more privileged backgrounds also experienced feelings of powerlessness as they remained largely economically dependent on their husbands or sons. Two carers (mothers) who had already spent years caring for their sons at the Shrine hoped that one day they would get better and take control of financial responsibility at home. Until then, they relied on begging and donations, surviving on a very low income.

Spending money on any type of healing regime was difficult when people were hardly able to meet basic needs. RIZWANA described her situation:

'He (*husband – breadwinner*) doesn't do anything now because he can't see anything – almost blind... he used to work in a shop making slippers. We were doing very well financially but since this problem has begun, we are hardly managing something to eat.'

The cost of other forms of healing was often prohibitive. Those who had consulted faith healers reported that they charged very high fees and even then the results were not always satisfactory. When they did experience some relief it was only temporary. FARHANA talked about the cost of faith healers and contrasted this with what she saw as the guarantee of success at the Shrine:

'...these healers work only if you give them money. If you give them less money, they will not work or will do temporary work whereas at the Shrine of *Baaba*, you don't have to worry about any of that. Here every body that has faith is given healing. It is just matter of having total faith and I have that.'

Some attendees had experienced extreme social adversity, loss and trauma. One example of this was SABIHA (a carer) who came from a family where the male members, her husband and sons had been heavily involved in local politics. As a direct result, her husband and a son had been murdered by unknown assailants and her other son was kidnapped, kept in a police cell and tortured for 4 years. In these desperate times, all she could hold on to was the female Saint Maai Makli¹¹ whose shrine was nearby:

‘...he (son) was missing...I used to come to the shrine of Maai Makli and cry here for days to bless me with my son again. One day when I went to sleep while crying, I had a *bishaarat*¹² and the Maai told me to go home. As soon as I came home, I got a phone call about him being seen at the police station... Then I went from one prison to another and it took four days before I found my son in a torture cell. They had beaten my son so badly that I can't explain’.

Long term experience of poverty and traumatic life events were not uncommon. To some extent, lack of financial resources influenced help seeking in terms of what could be afforded or was considered cost effective.

EXPERIENCES OF SEEKING MEDICAL TREATMENT AND HELP

Many attendees at the Shrine had been to doctors, either in local clinics or hospitals to seek help for the problems they experienced. Most of them had been sent for diagnostic tests including X-Ray, ECG, Ultrasound, and blood tests, not all of them seemingly necessary. They were prescribed medications or told that there was nothing wrong with them. WARI was one who had been through

¹¹ Mai Makli - was a small shrine for a female Saint, located locally and attended by some followers.

¹² *Bishaarat* - a special and private communication or conveyance of message from the Saint to the attendee.

many investigations. A failure to diagnose the problem medically led her to try the Shrine:

‘(doctors) thought it was heart problems and others thought it was something to do with the brain. Some also didn’t believe that I had any problem because I didn’t look very ill... I went through so many tests and investigations but nothing came to the surface. We kept on saying that there must be something otherwise why would I suffer but they couldn’t find anything. That is the reason now we have come to the Saint of Allah to help and alleviate my suffering.’

Some attendees believed that doctors could help them and used medications for many years. However, when this treatment did not meet their expectations for improvement or recovery, they referred themselves to the Shrine. This was the case for NASR:

‘I went to so many different hospitals and doctors and had my heart checked. They admitted me for short and long stays and gave me a fistful of medication, but to no benefit at all.... I was on my bed for almost four years. The only time I went out was the time when visiting doctors. My daughters were so young; often there was no food for the children.’

There was an overall expectation that diagnostic tests would lead to a firm diagnosis and therefore treatment and an alleviation of symptoms. When the process was not so straight forward, many attendees became confused. AKEELA began to believe that her problem was supernatural when she received conflicting opinions on the results of her chest X-ray:

‘I had a very bad cough which lasted for a long time. Upon assessment, I was told that it was tuberculosis but after sometime when I had it tested by another doctor, he couldn’t see anything wrong. It should be like you have TB or you don’t have TB’.

There were some who had contacted hospitals for a problem when they felt that their family members had gone ‘crazy’ or ‘had flipped their mind’ (from my professional assessment they appeared to be referring to a psychotic breakdown). Unfortunately the health professionals consulted did not clearly explain what was wrong with the person and left the carers or attendees bewildered. RANA’s mother who reported her daughter as disinhibited and frequently trying to remove her clothes, explained:

‘A lot of people said that we should go to a doctor. My elder son said that we should go and see a brain doctor. We went to the one whose hospital is near our place, they could not identify the problem. They gave us some medication and she took it all, but it made not a bit of difference.’

SUBHA who was educated and working in a computer company appeared to have suffered from depression and panic attacks. However, she was told by a doctor to ‘not worry and be happy’ as nothing was wrong with her. She felt patronised and confused with the whole approach.

Interestingly some attendees seemed to be able to isolate particular problems as having supernatural causes, while others were perceived to be physical in origin and required medical treatment. The differences between the two types of problem were not obvious to an outsider. One attendee explained that if a person was experiencing symptoms and the reports did not show any abnormality, then it was suggestive that the problem was not medical but supernatural in origin. This reinforced their belief that medications would not help them and they stopped taking them.

Those who referred themselves to private hospitals and paid for all diagnostic tests often felt betrayed when they were told that all the reports were clear, that no abnormality could be detected and consequently no treatment offered. SUBHA had undergone extensive investigations:

‘I did go to doctors and had my head checked – they said all is normal, there is nothing abnormal. I also went to cardiac hospital and they had my heart strip done (*ECG*) but that was also normal. They said there is nothing abnormal. The clinic where I had my brain checked even said that I am very clever and sharp. Which means that this is a different problem?’

Many described a lack of trust in medical help. They cited examples of treatment being given without consent or explanation, expensive diagnostic tests being ordered without explanation, lengthy hospitalisation without any positive outcome and health professionals’ doubting the genuineness of their symptoms. Kauser described how a doctor had doubted her daughter’s pain:

‘I was so upset, how dare she say that. My poor daughter is in so much pain and they think we don’t have anything else to do other than pretend to be sick. These treatments take so much money and still don’t fix the problem.’

NAGRI found ECT being given to her son without any information being given to the patient or the family. She perceived this to be detrimental to her son’s health and developed mistrust in medical interventions. She described what happened at the hospital where her son was admitted:

‘They said they are doing some treatment... One day when they took him in for the treatment, I wondered what they were doing. So I followed them and stood outside the treatment room. The door was not completely closed so I tried to peep in to see what was happening. I saw that they were putting some electric current to my son and he was convulsing. I got very scared seeing this and thought what sort of treatment is that. I was very upset and I went to my father and said lets take A. (*her son*) back home because they are putting electricity in his head and what good would that do?’

Some attendees reported that when they contacted doctors about their ‘problem’ they were given a prescription for medications which often made them ‘very sleepy’. They resisted these medications as they feared addiction to the drugs or damage to their internal organs. Some were also told by their relatives or acquaintances that these medications were only for ‘mad’ people which left them feeling let down by their doctors.

NAGRI had been concerned about her son’s behaviour and took him to a doctor who prescribed sedating medication. The medication not only made him very drowsy but upset the whole family:

‘the doctor gave him an injection and a big packet of pills. I started giving him pills, which he would take without resistance. I don’t know what was in those tablets but my son was drowsy and sleepy the whole time, he would just sleep and sleep. This went on for such a long time... his wandering around was over but now he was sleeping in the house the whole day. I would wake him and say please get up and eat but he would not. Such an adult son and I was taking care of him. How is this helpful?’

AKEELA described the effects of medication prescribed to her by a psychiatrist:

‘He (the psychiatrist) had come from some western country and he gave some bottles of brown coloured tablets and suggested that I take it when I am not well. I started taking it and I lost consciousness most of the time. I was drowsy and sedated all the time. We showed it to someone and they said that it was for someone with madness and can be habit forming.’

Some attendees while at the Shrine continued to contact doctors or take medication for other health problems such as stomach ulcers or high blood pressure. Others declared themselves to be medication free and considered taking medication to be a sign of lack of faith or belief in the Saint’s ability to

grant them healing. SADA explained why she did not want to take medication; side-effects and cost were clearly issues:

‘The medications have a hot effect and it causes constipation which makes me feel worse. In addition, these medications are not cheap. It may cost up to Rs. 100 (*£1- cost of 5 meals on average*) for one day. Due to this, I thought about coming here and putting a request to the *Baaba*¹³ so that I become well again and can get rid of these medicines forever.’

The attendees frequently found the cost of medical help prohibitive. Each visit to a doctor cost them money. Even in state hospitals, each person is required to pay for medications, which were often expensive. SADA again outlined the theme of cost effectiveness:

‘I am not going to take any medicines now and this is my aim. These medicines give more of an adverse effect than helping my health. Why spend so much money on these medicines when all they do is to make me feel worse?’

Sometimes people contacted doctors in acute situations but came to the Shrine for help with more long-term or chronic conditions. Medicine might have been considered beneficial as first aid or for immediate relief but it was not seen as a long lasting solution or cure:

‘You can be treated there (*a hospital*) but that relief is temporary; here (*the Shrine*) you can have permanent relief and total healing... If we are not able to come here, then for temporary relief we may go to the doctor who may suggest some treatment.’ (RAFIQUE)

¹³ *Baaba* - A term generally used for an older and respectable man. Sometimes used to refer to one's father. In the current context it is used for the Saint - Hazrat Abdullah Shah Asahabi

There were those who sought treatment at the Shrine as well as from hospital at the same time. One informant believed that both treatments could work concurrently:

‘She (*daughter*) was in a hospital and taking all the treatment, but it was *Baaba* who actually prayed to Allah for her. Because when I was pleading, I saw *Baaba* in my dream and that was a *bishaarat* that *Baaba* will get onto my case.’ (INF-F-34)

Another attendee MOADIT believed that medical and supernatural problems could be differentiated and was certain that he would be directed by the Saint to the appropriate source of help:

‘*Baaba* will tell me clearly when the problem is not related to magic or possession and it is due to some medical problem. For example, a few days back I had a constant *hazri* for days and nights. I had a severe pain in both sides (*flanks*). During *hazri*, the *Baaba* told me that you have kidney stones and you should go and see a doctor in some hospital. When I went to a doctor, she checked me and carried out some tests. Then she checked those ultrasounds and said the same thing, that I have kidney stones. She gave me some medications which crushed those stones and it came out in my urine.’

For others, the logic behind receiving medical treatment for purely physical problems such as enlarged goitre, dysmenorrhoea, or epileptic fits was rejected. The problems were perceived to be the ‘work of the devil’ and authority was given to the Saint to treat it without any medical or surgical intervention.

Most of the attendees had at some point in the history of their problem or illness consulted a medical practitioner. All had experienced a degree of dissatisfaction and many were confused by the explanation or treatment given. Medication was seen by some as a temporary treatment, whilst others made a distinction between physical, medically – treatable problems and those of a supernatural

nature. Side-effects and costs of treatment fuelled negative perceptions of medical treatment along with disappointment in overall outcomes.

Attendees came from a social context which commonly included domestic violence, trauma and poverty. Women felt largely powerless within their family and the prevailing social order. The problem behaviours displayed were stigmatising and led to social exclusion.

Help seeking choices were sometimes financially driven or influenced by unsatisfactory experiences of medical help or a lack of improvement and recovery. This combined with the social impact and perceived severity of the problem, and beliefs about the power and process of magic and possession and the supernatural causation of problems, led attendees either directly or via other (failed) treatments to the Shrine and treatment from the Saint, Abdullah Shah Asahabi.

THE SHRINE AND THE HEALING PROCESSES

On arrival at the Shrine, via a long winding track through a vast cemetery, attendees entered an alternative community of people with similar beliefs in the power of the Saint to heal. The ‘treatment’ and process of healing was complex and fully known only to those attendees engaged in the largely hidden interaction and communication with the Saint. The highly visible part of the process, the apparent battle between the ‘good’ Saint and the ‘evil’ jinn was played out in front of the *durgah*. This, along with other aspects and rituals of daily life at the Shrine were identified by attendees as crucial to their hopes for a miracle.

BELIEF SYSTEM AND THE HEALING POWER OF THE SAINT

Hazrat Abdullah Shah Asahabi, the Saint buried at the Shrine was considered by attendees to be the highest authority among the Sufi saints of Pakistan.

An attendee (INF-M-06) who lived at the Shrine related that the Saint was actually a grandson of Ghous Shah a Sufi saint from Baghdad also considered very high in the hierarchy of saints. The title 'Asahabi' means 'friend', a title which was given to those who were friends and close acquaintances of the Prophet Muhammad (PBUH).

He (the Saint) spent his life devoted to Allah and detached himself from worldly matters. According to the attendees he is the beloved of Allah and has been given healing powers by Him. The spirit of the Saint was thought to use healing powers to negotiate with the evil forces or jinn, to weaken them, destroy, or burn them, or to convert the jinn to Islam. It was believed that the Jinn would become friends or protectors of attendees following conversion and help them get better. For FARHANA, like many other attendees, the belief in the Saint and his ability to help was not new, but one she grew up with:

'I used to read the Qur'an and sing devotional songs for Allah, his Prophet [PBUH] and his saint, who would shower their mercy on me and take my sufferings away. I have always turned to them in times of difficulty and distress and he (*the Saint*) has great mercy on me. He knows that I am an orphan, I have no support, and I have been a follower of the shrine since my childhood.'

FAZAL expressed his reverence for the Saint:

'...people come here to pay their respects to the sacredness of this Saint and the Shrine. His position is like king and we are like needy, like beggars, begging for his mercy and he provides peace and comfort to all. If you sit here for an hour, it feels like current passing through blood, spreading peace in the body.'

INF-F-3 described their family tradition in relation to the Saint and the Shrine:

'Paying respect to a *wali* [*God's beloved or saint*] is a religious ritual in Islam. In our family, it is a regular practice. We visit shrines, offer

donations, put flowers on the grave, distribute food or sweets to other attendees. This brings prosperity and blessing for health, wealth, and joy'

This was similar for SADA

'My parents were great believers in the shrines and saints. They used to come here regularly and they brought us here to pray for healing and general well being'

The role of the Saint (or *Baaba*) was described as that of a guide or instructor who facilitated and administered the healing process. He was seen as an authority or parent figure who helped the attendees to understand what was wrong with them, set ground rules and boundaries for acceptable and unacceptable behaviours and helped them to get better. He also set the pace and nature of the treatment process, keeping it flexible according to an individual's situation and context. In return for complete dedication, total faith, and surrender, he offered healing and well being.

Attendees narrated many stories describing healing miracles they believed had been performed by the Saint. These included treating people who were on their deathbeds, people with incurable illness including the last stages of cancer, severe possession problems (those they called 'crazy') or those for whom doctors had given up hope and treatment. One attendee with whom I conversed informally commented on how she had seen many people who were so out of control that they had been chained for days at a time but were so transformed by their stay at the Shrine that they were able to walk out unaided (INF-F-02).

The miracles reported also included overnight treatment and cure of cancer, 'operations' where gall bladders or an appendix were removed, or complicated abdominal surgery carried out during the night and people woke up to find stitches in their abdomen. HAMAD described the treatment of a young girl in a serious condition for whom doctors had said there was no hope of a cure:

‘It was time of ‘*Goosul Mubarak*¹⁴. I brought a bottle of water from there and some oil from the lantern, which is lit up near *Baaba*’s grave. We fed that water to the girl and massaged her body with that oil. Within a day, the girl opened her eyes. They (*family members*) all were quite shocked to see the recovery. Not only the family but doctors were also surprised and were asking what has been done. The girl then had diarrhoea and vomiting for 2 two days when all the impurities and evils were purged. Since then the girl is perfectly fine and her parents bring her to the Shrine at every *nochandi* to thank *Baaba*.’

Another expressed complete faith in the Saint’s ability to cure very serious and even terminal illness:

‘I have seen people coming here crying and going back laughing. People come with declarations from doctors that they are incurable and they go back from here in a perfect state of health.’ (FAZAL)

Some attendees reported that they had lived in distress for years before finally coming to the Shrine and finding immediate relief from some symptoms. Family members witnessed more control over embarrassing behaviours such as aggression, talking to self, disrobing, or disinhibited behaviours. The relief achieved without medication and/or diagnostic tests affirmed their belief in the healing powers of the Shrine and the dead Saint and encouraged them to stay. Although not all were entirely sure what was helping, the improvement in symptoms/condition was enough for them to continue.

It was acknowledged that different attendees found different saints to be the most effective healer for them and attended different shrines – but all the Saints were believed to work together to provide healing and comfort. At times, a

¹⁴ *Goosul Mubarak* - the ritual bathing of the grave of the Saint which occurs once a year; drinking the water used for bathing the grave is considered healing

whole village adopted a particular saint as ‘theirs’ and paid their collective respects on a weekly or monthly basis. INF-M-34 was an example of those who had been coming to the Shrine for the last 20 years and brought others who were unwell and/or wished to visit the Shrine.

Reverence for the Saint demanded that extreme respect and dignity be demonstrated at the Shrine. Thus, women were encouraged to cover their heads while in the premises, people when sitting would not direct their backs to the *durgah* (room containing the grave of the Saint). Women were also not to come to the Shrine while they were menstruating and sexual activities were prohibited while on the premises.

One woman who had been coming to the Shrine for the last 32 years and was a devoted follower, described herself as ‘like a daughter’ of the Saint. She became upset and distressed when describing how some people showed disrespect by entering the sacred place in shoes or came near the *durgah* whilst menstruating (INF-F-14). Following the ‘rules’ demonstrated the sacredness or sanctity of the Shrine, showing how special it was.

The Saint was considered the highest among all saints and was therefore assumed to have great powers of healing. For attendees, belief in the Saint was a part of their family tradition and world view. Stories of miracles formed a major part of the narrative and background of the Shrine and rooted attendees belief and hope. They included stories of cure of the most serious of illnesses and sometimes instantaneous relief. The reverence for the Saint was almost tangible and disrespectful behaviour was frowned upon.

RELATIONSHIP WITH THE SAINT AND THE SHRINE

The importance of the relationship between the attendee and the Saint and the relationship between the attendee and the sacred space of the Shrine emerged

very strongly during the interviews and was clear in observations of attendees' behaviour. There were two main ways through which attendees communicated or interacted with the Saint: *bishaarat* and *hazri*. Through these two forms of communication and/or 'treatment', a personal and individual relationship developed between the person seeking healing and the healer.

Bishaarat

Bishaarat was a special and private communication or conveyance of message between the Saint and the attendee. Through this message the Saint communicated instructions to the attendees concerning how the problem could be addressed or healed. A *bishaarat* was often given during a half sleep in the form of a dream. At times the attendees heard a voice or saw a vision of the Saint. Events in dreams were viewed symbolically and interpreted as important instructions or messages from the Saint. Some people considered that having a *bishaarat* signified the Saint's approval of their loyalty or service and that they had been blessed.

For INF-F-31, dreams of a bus going to Thatta (location of the Shrine), buying a ticket for travel, sitting at home with the family, eating *lungghar*¹⁵ at the Shrine and walking towards the Thatta bus stop were all thought to communicate messages from the Saint. These were encrypted messages, left for the individuals concerned to decode.

It was acknowledged that not everyone would be able to recognise or understand the message implicit in the *bishaarat* and may consider it to be an ordinary dream. Only believers in the power of the Saint would perceive and

¹⁵ *Lungghar* - The food distributed at the Shrine – it could be a piece of sweet or a meal served in an alms house

understand the message. One attendee, INF-F-30 described a *bishaarat* which she interpreted as the Saint calling her to the Shrine:

‘I had a dream in which I saw signs for the Thatta shrine. I told my husband that I would like to go to Thatta but he just distracted me on to other things and I forgot about it. As the problems at home continued and became worse, I got more *bishaarat* about coming to Thatta but my husband said that we don’t have enough money. Then my *Baaba* somehow caused a miracle and we won a lottery and with that money I came to Thatta and stayed here for 40 days.’

At times the *bishaarat* gave detailed instructions on what to do, where to go, what to eat, and who to interact with:

‘They tell us where to sit, where to lie down, what to eat, and what not to do. He also gives instruction about what rituals to follow like the distribution of food or cloth or other items...*Baaba* can tell people to avoid going to certain places in the Shrine.’ (SUBHA)

The attendees described how the Saint gave messages verbally, or showed them pictures, scenes, or items which had symbolic meanings. INF-F-35 differentiated between a *bishaarat* and an ordinary dream:

‘It is not a dream. For example I got it when I was falling into sleep, I was still awake – during half sleep, and I never get any *bishaarat* during deep sleep. *Baaba* called me through *bishaarat*, I was shown the *jaali*¹⁶.’

Some attendees like SABEEHA, felt honoured to receive a *bishaarat*, and felt that they had to obey it regardless of their circumstances.

‘I had it in my dream. How should I tell you what it was (*sounded excited, struggling with words*) I saw that I was sitting in a corner of the Shrine

¹⁶ *Jaali* - Metal grill covering the windows fixed in the *durgah*. People from outside the *durgah* would touch the *jaali* to see the grave and to communicate with the spirit of the Saint.

here and a saint looking man in a pure white outfit comes and tells me to go to Thatta. I told him that I don't have money but he said go there. I am such a little invisible thing in the Shrine and I was honoured with *Baaba's* vision in my dream. After that I couldn't stay there (*at home*) because I was ordered to come here.'

Some received instructions to come to the Shrine and others to go home. SEEMA described what she saw:

'Sometimes when *Baaba* wants to call me, I get a *bishaarat* and I see a bus which is coming to Thatta or I see myself sitting in the bus. Or I see a group of people walking towards the Shrine. This means that *Baaba* is calling. When *Baaba* wants me to go home, then I see myself sitting at home with my children and looking happy, so I get that and go home.'

A *bishaarat* showing the distribution of food to people signified the need to offer food or money to the poor and needy. Seeing themselves going home and then becoming ill again showed it would be detrimental to the attendee's health to return home at that stage. Scenes from a hospital such as sitting in a hospital waiting area, creams, injections, or being on a hospital stretcher were interpreted as the need for the person to attend hospital as their problem required formal medical treatment.

A male voice, deep and talking softly or a tall old person with a white beard and a long white robe speaking to them was believed to be the '*Baaba*' or Saint and a dream in which the Saint was applying chains to a devil like creature showed the attendee that the Saint had gained control over the evil spirit.

It was considered essential by most attendees to follow the instructions or the consequences could be dire:

'If a person has not been given any message about going home and still a person goes home, then something or the other will go wrong on their

way. Probably the van will breakdown, or will have an accident or the journey will be full of discomfort. However, when it is *Baaba's* agreement that we should go, then the journey back is very smooth and we also find everybody happy at home too. If we go against *Baaba's* wish, then all goes wrong. The problem is that those things become powerful and they (*evil spirits*) can actually get us killed too.' (INF-F-35)

Some attendees said they had heard that a stamp or ink blot appearing on the hand or restraints or metal ankle chains being removed signified that the person had been discharged from treatment by the Saint.

Some women talked about how if they did not act immediately on a *bishaarat*, then the Saint gave them the same message in a different way. For example, a woman who was told in a *bishaarat* to go to another shrine, but waited, then saw two ants crawling on her arm and biting her. She perceived this to be a message from the Saint saying that if she delayed any longer, she may be vulnerable to another attack of magic.

RAFIQUE's sister strongly believed that a *bishaarat* had to be followed:

'It is a sin to not come here when you are called. It is equal to inviting more difficulties and troubles on to you and your family. If one had a dream about coming here, then he should come here.'

The fact that the *bishaarat* was hidden from public view and known only to the attendee receiving it, in the first instance, in a way empowered the individual. Knowledge of the content of the *bishaarat* remained with the attendee and that they could choose how much they shared with others. The symbolic nature of the content of the *bishaarat* also allowed a degree of flexibility in how they interpreted the 'message'. In this way, the belief in the power and decision making of the Saint and the respect conferred on him were 'transferred' to the

attendee as they relayed the *bishaarat* to family members and those around them.

Hazri

The *hazri* was one of the most common forms of treatment attendees experienced and talked about. It was described by the attendees as a process in which there was an interaction between the Saint and the evil forces which were residing within the attendees' bodies. At the time of the *hazri*, the attendee went into a trance and remained detached from the process taking place. Observers witnessing the process saw and heard one side of a dialogue between the Saint and the attendee. The attendee appeared to be answering the Saint's confrontation in a voice unlike their usual voice, which was assumed to be the voice of the jinn.

RANA and then her mother explained the process:

RANA: '*Baaba* doesn't talk to me but he talks to this thing (*the evil*) and then this thing answers him and that is how we learn what we are to do'

FP: 'What thing?'

Mother: 'The jinn which is inside her. *Baaba* talks to that jinn and he answers *Baaba*. During this conversation, we learn from the jinn's answer what we are to do. She (*RANA*) loses her senses completely during that *hazri* and then afterwards asks us what happened'.

A person during *hazri* was in a state of trance and described as unaware of the environment around them. I witnessed a young man and a young woman on separate occasions banging their heads on the wall with great force. I also saw a young woman scratch her arm with a broken glass bangle to the point where it bled quite badly. Some attendees reported having seen other attendees in the trance like state or *hazri* swallowing crushed glass bangles. There were incidences of attendees running and somersaulting around the Shrine

compound for as much as an hour at a time. It was generally assumed and reported that it was the jinn who was trying to harm the attendee as a punishment for coming to the Shrine for treatment and enlisting the help of the Saint in fighting the evil. Others also explained that it was the Saint trying to punish the jinn that had possessed the attendee.

Different people experienced *hazri* in different ways. People often differentiated between an 'open' and a 'closed' *hazri*. An open *hazri* referred to an open display of a 'treatment' being given or taking place and the enacting of this was usually witnessed by other people. A closed or *ghum hazri* referred to a state such as sleep or drowsiness when the attendees believed that the Saint engaged with the evil forces and worked on relieving the person of the possession. This form of *hazri* was not observable from the outside and appeared to be experienced less frequently than an open *hazri*. MOADIT explained the differences between the two.

'In a *ghum hazri* a person remains quiet and calm but *Baaba* works underneath and solves the problem. This is less painful. Other people have open *hazri* which means the person is made to somersault all over the Shrine premises and is also thrown from one place to another. This is very painful but most pain is actually directed towards the devil inside the person. The physical pain to the person subsides after a short while.'

SABEEHA described the behaviour of her son during what she believed to be an open *hazri*:

'He would run around, somersault, bang his head on the wall, or on the metal tanks. He screams loudly during the process and sounds like he is in a lot of pain. After *hazri*, he remains lifeless on the floor for 2-2½ hours. After that when he comes out of it, he is completely normal but it takes him 5-6 hours to come to that stage. After that he will be running around helping everybody, being nice to people and nobody can even think what has gone on just a few hours before.'

Attendees were also observed to sway their head and hair from side to side and stamp their feet on the floor for long periods of time. They also made sounds or noises such as, – humming, purring, grunting or changes in the voice – often women were heard talking in a hoarse and deep masculine voice. Some people seemed to be talking to the Saint, saying things such as ‘Asahabi, leave me’, ‘what have I done to you’, ‘let me go – I promise I will not disturb her again’, ‘do what you want, I am not leaving’, ‘what can I do she stamped on my children and my children died’. Many times sexually explicit content was spoken aloud during the state of *hazri*, mostly focusing on love affairs, seduction, sexual acts or swearing.

The attendees who experienced *hazri* described that during that state; they had no control over their bodily movements, their speech, or behaviour and denied any memory of the event. Everything that was done during this state was accepted by the audience and responsibility for the ‘unacceptable behaviour’ was placed firmly on the jinn. Each *hazri* appeared to be an elaborate performance – there was a slow beginning, rising to a peak or fever pitch and finally ending with the person prostrate in front of the *durgah* or near the *jaali* (described as the evil spirit surrendering in front of the Saint). Often on completion, the attendee either collapsed on floor or went to sleep.

MOOMAL described the evil force as a tumour in her body that the Saint was removing by excising the body bit by bit. She felt she had to stay at the Shrine until most of the evil was removed from her body. I could see incision marks (*healed scars*) on different parts of her body, especially on her arm, behind her ear and on her abdomen, it could not be determined if these were self inflicted or acquired.

‘these cut marks – incisions that you see, I have these all over my body, and during *hazri*, the *Baaba* slices this beast out of my body through these incisions.... this thing is pulled out in pieces from my body. It hurts a lot, but less than the suffering I have been through’

The relatives saw a significant difference in the attendees' behaviour pre and post *hazri*. The person appeared calmer and more in control of their behaviour afterwards. They behaved appropriately and appeared subdued.

One example of a *hazri* that I observed was:

A boy of about 12-13 years, who appeared tired and exhausted, was brought in by his family. They left him in front of the *durgah* and went to the Shrine compound. He went into the *durgah* and then came out. He had a drowsy look in his eyes and appeared unaware of his surroundings. Then he started running around the compound. It took him about 3 minutes to complete a circuit of the Shrine compound. After about 8-9 laps, he started somersaulting in front of the *durgah* while other people were sitting and praying. People moved and cleared space for him to continue what he was doing. In the process of running and somersaulting, he appeared to become increasingly tired.

The following conversation took place between me and another attendee who was observing the boy. I was given permission to tape record this conversation:

FP: 'What is happening to him?'

INF-F-33: '*Sarkaar (the master – the Saint)* is beating him...'

(The boy started banging his head against a metal trunk, repeated loud banging). 'It will not hurt right now, but when he regains consciousness, it will hurt him a lot. What to do, he has to have *hazri* otherwise how will he get better?'

FP: 'Do all get similar sorts of *hazri* here when they come for their treatment?'

INF-F-33: 'Yes it can be this way or quiet ones.'

(The boy started talking in a very coarse voice; all the words could not be understood. 'Asahabi... Asahabi... Asahabi leave me' – after a few minutes, he started long repeated grunts and then sat in front of the durgah, with his head down and continued grunting.)

INF-F-33: 'He is now talking to the *Baaba*...it is totally up to the *Sarkaar*, for some it may take up to an hour; some people are relieved in 5 minutes. For some it may continue for 24 hours.'

Although the process of open *hazri* was described by all of the attendees as painful and difficult, it was considered much more bearable than the actual ailment they suffered from. MOOMAL described the pain she experienced after *hazri*:

'I get such severe pain in my whole body that it feels like someone has beaten and thrashed my body with a stick, but then the pain goes in 2-3 days and I am better again, no tablets and no drips. I just ask my daughter-in-law to give me hot black tea to drink and after drinking that I fall asleep.'

Some attendees experienced what they described as '*ghum hazri*' (closed or quiet *hazri*). Frequent turning and tossing during sleep was considered to be a sign of a '*ghum hazri*' in which the 'Saint burnt or destroyed the jinn', causing this apparent restlessness (INF-F-1). Many used terms such as 'undercover' treatment, to express the workings of a '*ghum*' *hazri* as it was something that they remained unaware of until later when the Saint informed them that it had taken place, through a *bishaarat*.

Excessive sleeping by the attendees was also considered a sign that a closed *hazri* was taking place. SAIMA's mother described a change in her daughter's sleep pattern which she perceived to be a closed *hazri*:

'She has been sleeping so peacefully for the last two nights. In my view it has been at least one and half years since she slept well. And this is our fourth day and she has already been sleeping really well.'

Whether it was the process of sleep (rest and relaxation) or the experience of *hazri* that improved their sense of well-being cannot be determined. The

attendees believed that outsiders would never understand the experience of *hazri* and therefore would misinterpret it or find it entertaining and amusing. There was a clear division between ‘them’ and ‘us’, those who believed and those who did not.

There was a consensus amongst attendees that the frequency of *hazri* decreased as they healed. Initially they might have had *hazri* constantly for 24 hours; however towards the end of treatment it became once a week or less. Some were permitted (by the Saint) to go home on condition that they came back to the Shrine at least once a month on *Nochandi*, so that they could have further *hazri* which seemed to act as a booster to the treatment already received.

WARI’s husband who has been staying with his wife for at least 8 weeks was finding it hard to prolong his stay for an indefinite period. He emphasised to her that if she asked the Saint for repeated *hazri* and prayed intensely, she would be healed more quickly and they would therefore be able to leave. WARI however felt that intense treatment was painful and distressing physically and mentally and these matters could not be hurried. This interaction showed an interesting dynamic and subtle shift of power from husband to wife.

Often people became calm and peaceful after the episode of *hazri* and remained subdued for hours afterwards. MOADIT described how he felt after coming out of a *hazri*:

‘...peace – immense peace. It is like that thing (*the evil*) tries to catch a part of your body but cannot do it as the *Baaba* is guarding it and has intervened on time.’

WARI’s daughter described the effects of *hazri* on her mother:

‘...after *hazri*, her condition actually deteriorates but then slowly it progresses and she begins to feel better... now she is able to sit relaxed, does some prayers, talks to us. Otherwise at home she was completely

bedridden. If we took her to the bathroom, she would go otherwise she would just stay in bed and wet the bed at times’.

The attendees denied having any memory of their behaviour during *hazri* (as they were in a state of trance), but often described the *bishaarat* they received after *hazri* to be the time when the Saint enlightened them with information about the causes of their ill-health and insights concerning the material and spiritual world. In this way, the attendees felt that they were given explanations of what, how and who had caused the problem and greater understanding about their lives and what needed to be modified. A mother (INF-F-08) shared her experience:

‘...during *hazri* *Baaba* shows them faces or gives an indication as to who the culprit is (*caused the magic spell*). However we are not allowed to talk about it or give away names to others.

Some people also saw the faces of their enemies:

‘I was told that someone had cast black magic on me... I was also shown faces of all those enemies who have cast magic spells on me.’ (NASR)

The act of receiving treatment through *hazri* and open display of the interaction between the Saint and the evil appeared to confer status on the recipients. The person, during the period of the *hazri*, was considered sacred as he/she was in direct contact with the Saint, and it was thought that through this association the person became holy.

Some attendees were given *bishaarat* (messages) intended for others during the trance like phase immediately following the *hazri*. These explained the cause of others problems or informed them of actions others must take such as the distribution of sweets or *lungkar*. I observed a woman having a *hazri* who later informed another attendee that she had had a *bishaarat* for her, and that an order was given for the other attendee to distribute a meal amongst 14

people. The woman seemed really happy and delighted that a message had been sent for her. There were also times when messages about going home were sent through other attendees experiencing *hazri*. The attendees were very trusting and receptive to suggestions, which may have left them vulnerable to exploitation. They could have been encouraged to part with their money or valuables or engage in activities they would not ordinarily engage in.

Sometimes people could be taken by surprise and receive a *hazri* or *bishaarat* without necessarily realising that they had a problem. One attendee felt that sometimes a person may be symptom free and still get a *bishaarat* to come to the Shrine, as they may be possessed by a jinn that is in a dormant state. At other times, people on a regular visit to the Shrine for '*Fatiha*¹⁷', received a *hazri* as the Saint fought to control their jinn. HAMAD shared his experience:

'Sometimes people come here to the Shrine to offer prayers etc. en route to other villages or on an outing. They have women with them, sisters or daughters who are enjoying themselves in modern dresses (*usually refers to top and trousers in a western style*). As soon as they enter the Shrine, they get *hazri*... *Baaba* catches the thing inside them which had not revealed itself yet. Parents get upset and shocked to find that their daughters are possessed'.

A *hazri* was usually a dramatic, outward, and public manifestation of the 'treatment' taking place. It was a visible enactment of the battle between the healer (*the Saint*) and the evil spirit possessing the individual. It involved acts of self harm and over activity and sometimes included a commentary on what was taking place, with observers able to hear what appeared to be one side of a private conversation between the jinn and the Saint. For those who experienced the trance-like state of the *hazri*, it was a painful process but also one which was

¹⁷ Fatiha - A visit to a shrine by followers to offer prayers and respect for the dead saint, so that their lives can be blessed.

ultimately rewarding in terms of relief from their symptoms and spiritual enlightenment. The more dramatic or violent the *hazri*, the greater the regard in which the attendee was held by others. It was as though attendees took on a new identity during the *hazri* as they acted in unusual ways and a new identity also began to emerge post-*hazri* as they were viewed differently by others and achieved a certain status.

Experiencing a *hazri* was considered an important and essential part of the treatment process at the shrine. The more *hazri* a person could experience, the quicker their recovery.

Physical proximity to the sacred

The attendees described a very affectionate relationship with the dead Saint. They located the spirit of the Saint within the geographical boundaries of the Shrine. This extended the relationship with the Saint to include a relationship with the place (the Shrine). They felt listened to, taken care of, and hopeful for change in their circumstances. Many attendees described how they had found a true guide and powerful protector in the Saint and how their lives had changed completely since they had found the path to the Shrine. When they felt restless, agitated, or low, they just had to go and hold the *jaali* to be reminded that they were cared for.

Proximity to the grave of the Saint and being physically present in the Shrine seemed very important to the attendees and their families. All male attendees and family/friends circled and touched the grave in the *durgah* in order to achieve a level of healing. Although females were not permitted to enter the *durgah*, they asked males (attendees or the caretaker) to touch the grave with a bottle of water, or packet of flower petals or sweets so that they could consume these items as holy potions to aid their healing. Most of them considered anything that touched the grave of the Saint to have medicinal properties. The oil which was used in the lanterns burnt around the grave was used to massage

the body and relieve pains, aches, or weakness. The diluted form of this oil was also sold in the Shrine shops and was purchased by attendees or visitors. In this way, a piece of the Shrine was taken away and used in everyday lives as a reminder of their relationship with the Saint and the place.

SADA ate flower petals and water that had touched the grave of the Saint, as a supplement to medication:

‘I take these things home too and consume them as it helps me keep well. Otherwise when I take medications three times a day, for a whole week, then only I feel better but combined with flower petals and water from the Shrine, I have to take medicines once a week only and I feel equally better.’

Another woman (INF-F-13) had been brought because she felt very unwell. She experienced severe breathing difficulties, which interfered with her sleep and appetite, as well as other daily life activities. Upon coming to the Shrine she started drinking water from a bottle that had touched the Saint’s grave and ate rose petals, taken from the grave. According to her, this had improved her health almost 90% and she was just waiting for some more improvement before heading home.

Some attendees explained that they could experience *hazri* at home but physical distance acted as a barrier to the Saint in his fight with the evil and therefore a physical presence at the Shrine was preferable and conducive to healing. In addition, stressors at home may have prevented them from having complete concentration on the healing process. Attempting treatment at home may also have interfered with and delayed the treatment process and increased their pain and distress. For many of them, being at the Shrine was as close to a higher being – Allah, as they could get.

Often those who were difficult to manage at home became very calm and settled as soon as they entered the Shrine. SABEEHA (a carer) explained what had happened to her son:

‘He runs from home to come here. He would wake up in the middle of the night and ask me to come with him to the Shrine. He would say if you don’t have money, then beg for it but we have to go... He said that he feels that someone is pulling him towards the Shrine. If I delay at that time or refuse to go, he starts swearing, hitting others and breaks things.’

The Saint was believed to be able to bring uncontrollable behaviour under control. This was described by INF-F-1:

‘She has jinn inside her, which cannot be controlled by anyone. She is so strong and wild that nobody can control her. We have been to so many doctors and other type of healers but to no benefit at all. The only thing, which controls her, is the *Baaba*. As soon as we bring her to the Shrine, she is peaceful and relaxes. *Baaba* takes complete ‘control’ you can’t even think that she can be so powerful when you look at her here.’

RANA’s mother who had been at the Shrine for a long time confirmed that her daughter’s behaviour could not be controlled anywhere other than at the Shrine:

‘As soon as we go (*home*), instantly conflicts and fights start, somehow family members lose their senses, take out sticks and knives, and attack each other (sigh). Our time is very hard...we can’t leave this shrine’

This was also the experience of another carer, NAGRI:

‘When he (*her son*) was unwell, he used to beat me. Hit me so hard that I would be aching for days. But now his behaviour is very much under control’.

Many attendees and carers described feelings of great peace that they were only able to find at the Shrine which they could not always recreate at home. This was the case for FAZAL, a carer:

‘I am in a state now that sitting here gives me immense peace, which I cannot find anywhere else. Twice I went to India to see my sister, including the journey; I stayed away for 11 days. I just felt *ghabrahat* and restlessness, which I cannot describe; I just never want to leave this place because outside these things (*evil spirits*) overcome us and make us miserable’

Many women, after leaving the shrine attempted to recreate the healing environment by developing *Astaana*¹⁸ in their homes, giving them a similar sense of healing and comfort. Some women described growing up in a home where dedicated space or *Astaana* was part of their environment. FARHANA was one of these:

‘We were quite young ... I remember that we used to come every *nochandi* Thursday with him (her father). We had an *Astaana* at our house. Because we were followers of all these saints, I was saved and kept alive.’

In this way, a sense of contact with the Saint and therefore healing was made accessible on a daily basis to those who believed in his power.

It was clearly important for the healing process for the individual to be physically present at the Shrine. The Saint was considered able to control the uncontrollable and give medicinal properties to everyday substances. Attendees experienced feelings of enormous peace as they connected with the place.

¹⁸ *Astaana* - Proxy shrine of the Saint in an allocated room/area of the home – the area is kept pure at all times and treated as a shrine. People visit and pay their respects and often experience *hazri* as well

Touching the grave or *jaali* seemed important in terms of grounding attendees within the healing place and some attendees even tried to recreate the shrine atmosphere at home.

THE LIVING EXPERIENCE AT THE SHRINE

The attendees explained that their main goal in visiting the Shrine was to achieve closeness to Allah rather than confronting those who had cast magic spells on them. They aimed to please the Saint by improving their behaviour, praying and adopting modest ways of living. If they managed to achieve this, the Saint would be able to heal them more quickly. They developed their own daily routine which was largely constructed around activities aimed at achieving these goals. Faith rituals, purging, wearing holy threads or adornments, eating *lunghar*, taking precautions, and attending the Shrine on particularly holy days were considered activities essential to the healing process.

Daily routine and faith rituals

The typical daily routine for the attendees included carrying out morning prayers, arranging for their breakfast, and keeping themselves occupied with relaxing and religious activities. They talked to each other, lay on the floor and rested, prayed or sang religious/ devotional songs, held the *jaali* and prayed to the Saint, and shared their stories and experiences of suffering with others. SEEMA described her daily activities:

‘I...read Qur’an, pray, recite holy songs, and clean the floor. That is it, what else can one do at a shrine?’

And similarly for ZARA:

‘I wake up quite early in the morning. Do my ‘fajr namaz’ (*1st prayer of the day offered just before sunrise*) and then I lie around. Have my breakfast – I make my own tea at Salma Baaji’s kitchen (*a corner in the hall where a few pots and pans are kept with oil stove*) and take biscuits,

or toast or bread from the canteen. Then I just roam here and there and pray and spend my time...’

Men attended the mosque for their prayers and sermons which were held on special days. Some attendees visited different nearby shrines as ‘instructed by the *Baaba*’ or cleaned the surrounding areas. HAMAD described his routine:

‘We read different verses of Qur’an, sing songs in praise of *Baaba* and Allah, talk with other attendees, go and hold *Baaba*’s *jaali* and cook our food. If there is *lunghar* we get food from there otherwise what we cook, we eat for a few meals.’

A daily routine and engagement in faith-based activities were clearly important.

Detoxification or purification

Some attendees also talked about purging as a way of cleansing or detoxifying their system and relieving them from all the magic spells. A few recounted how they had seen amulets or threads or pins and needles being expelled from their bodies in their vomit and stools during these purging processes. Several attendees experienced severe diarrhoea and vomiting soon after their arrival and for many, there was a significant improvement in their condition after all these substances had left their bodies. MOADIT described what he saw happening to his friend:

‘A friend comes here for follow up on each *nochandi*... Last time when he came here, he vomited a lot, and within 15-20 minutes, he vomited about 20 needles which were fed to him during a magic spell.’

INF-F-34 described a similar process:

‘I think some people didn’t like me being happy... someone had cast a magic spell... Put something in bread and made me eat it, after that I was so ill and had not had a moment of rest. Then my family members took me to another shrine. It was not even a day and I started to have very bad

diarrhoea. I didn't believe that I was under a spell but then I was given a *bishaarat* that this diarrhoea is my treatment as I have been fed by enemies.'

Although unhygienic conditions at the Shrine could have been responsible for an upset stomach, vomiting and diarrhoea were interpreted as the body being detoxified as the evil was expelled.

Thread and jewellery

Many attendees tied threads or chains around the door of the *durgah*, on the metal grill or around the trees in the Shrine compound. They considered these to be witnesses to the requests they were making to the Saint and also a form of protection. In the absence of the petitioners, these threads were considered by the Saint and wishes could be granted. SEEMA was wearing several metal anklets around both her ankles and explained why this was:

SEEMA: 'This means that that *Baaba* has now got control of that (*evil*)'

FP: 'how do you know this?'

SEEMA: 'my husband got a *bishaarat* that I was sitting in the Shrine wearing these anklets and I looked free from any pain or distress. This was a *bishaarat* that if I am wearing anklets, *Baaba* will have control over these things.'

FP: 'When will you take them off?'

SEEMA: 'when the 'asar' (*influence*) is gone, *Baaba* will give a *bishaarat* about taking these off too.'

And one person (INF-F-36) wore a thread for protection:

'Once we came here, problems started coming out and then I was told to tie this thread around me so that magic will stay away from me.'

Some believed that when their wishes were granted, the thread would fall off. However most of the attendees had 'heard' about this from someone else rather than witnessing it themselves.

SABIHA explained the significance of an anklet and chain worn by her daughter:

'One day she said that she saw an old *Baaba* wearing a black robe and he had long white hair and a beard. He told her to put the anklet on or it can bring problems in life... some people say that once she is healed, this anklet will open itself. The good news is that I can actually see that this anklet and chain is loosening up itself. I had kept it quite tight earlier but now as you can see it is quite loosely tied.'

The anklets and thread appeared to act as a symbolic reminder to attendees that they were being protected by a higher power and gave them comfort.

Lunghar

Eating *lunghar* (meals arranged/donated for all those at the Shrine) was considered a most important form of treatment. Regardless of their financial resources, the attendees and their carers gathered to eat the meals when they were distributed. Although the place was not very clean and the utensils used were not well washed, the food was treated as holy and blessed. It was the individual's responsibility to go and collect *lunghar* (dished out on plates) which would help them heal; in this way it was their own actions and efforts that contributed to healing. The following describes a typical distribution of *lunghar* I observed (OBS-33):

A message was sent to the women's residence hall through a child that *lunghar* distribution was taking place in a room behind the Shrine. Women and children headed towards the room in small groups. It was a large room, filled with people (both male and female), sitting on floor mats in neat rows. Beef curry and bread was served by two men. People

sitting to eat were also carrying plastic bags and/ or containers. Once their plates were filled, they ate a few bites and emptied the rest into plastic bags or containers. They then asked for a refill. A woman sitting next to me requested at least 5 refills, which were eventually emptied into a big vessel. Another attendee who was also a research participant emptied the remains from her plate into a plastic bag for later consumption, even though she appeared affluent (wearing gold jewellery and carrying a mobile phone). It was not possible to differentiate between poor, rich, educated, or uneducated, all were the same, sitting at the same level and eating the same food from the same plates.

Everyone without exception took part in the eating of *lunghar*. Some attendees took large amounts of food for later consumption which was probably related to matters of poverty. The quantity of *lunghar* consumed was not thought to hasten or improve treatment outcomes but taking part in this communal activity was considered essential.

Holy days

Nochandi, the first Thursday/Friday of the lunar month that begins Thursday evening and ends early morning on Friday, Urs Sharif (birthday of the Saint), Gusl Mubarak (ritual bathing of the grave of the Saint carried out quarterly) and Beesween Sharif (20th lunar day of each month - the day the Saint died) are all considered very significant. Hundreds of people and families visit the Shrine on these days.

Many attendees experienced *hazri* and *bishaarat* on these particular days. The days were often considered 'decision days' by many attendees, when they would be given insights into the nature of their problem, given a plan of treatment, or permission to leave. The attendees considered these days to be very holy and sacred as they believed that hundreds of saints gathered at the Shrine to heal the afflicted. People made special arrangements to ensure that they attended. Alms

were distributed in abundance, prayers were conducted, and donations given and received. Extra buses ran from different cities to the Shrine because of the numbers of people attending. Different prayer groups from the city came and created a special atmosphere for group prayers, and there was much music and rhythmic drumming to support the recitation of prayers. On these special days, many miracles were reported to take place.

Many people believed that attending the Shrine on these significant days also helped in detecting supernatural problems at an early stage of development so that treatment could be sought quickly. The attendees often described the purpose of their visit to shrine on these days as an ‘appointment with *Baaba*’, ‘a consultation with different saints’ or ‘follow up’ for their problem. The holy days which occurred with regular frequency served to inject greater hope for improvement and recovery. The arrival of a large congregation on these days validated the belief system of attendees.

Precautions

Attendees described how they were instructed by the Saint to restrict their activities. The purpose behind these restrictions was again to weaken the evil forces so that exorcism could take place. People were restricted from consuming rich food especially milk and meat, the idea being that rich food could make the jinn stronger and harder to get rid of. For example a carer (INF-F-36) explained the food restriction imposed by the Saint:

‘She (*mother*) has now been advised by the *Baaba* that she has to avoid any sort of meat because her ‘thing’ (*influence*) is sitting in her mouth and it will gain strength.’

The female attendees were also asked by the Saint to avoid using any make up or beauty products such as perfume, henna, or kohl, and from participating in weddings or birth celebrations. This was because beauty and make up could tempt the jinn and attending celebrations could make people prone to

possession as jinn linger in those places looking for vulnerable targets. These 'instructions' seemed to reinforce the idea that women's sexuality was dangerous and invited problems. It also suggested that women had a responsibility to protect themselves and not tempt those who could harm them. RANA gave an example of this:

'Until that happens (*exorcism of the jinn*), we can't do anything. I don't have permission for marriage, to wear perfume, to put henna in my hands or anything.'

Some attendees went to great lengths to abide by the restrictions placed on them by the Saint. For example, one woman who was interviewed had been living in a tent in the Shrine compound for the last three years as she had been instructed by the Saint to remain veiled (hidden), to protect herself from evil forces. She was referred to by other attendees as 'purdai wali khaala' (woman with a veil). She communicated with others through the barrier she had created and depended on others (mostly children and other residents) to bring her water and food. She said that she only came out once in the middle of the night to attend to her bodily functions. This behaviour would be considered eccentric in 'normal society' and stigmatise the person and their family, however, at the Shrine it was accepted and in fact conferred status upon her as someone very devoted to the Saint. Others also changed their behaviour to accommodate her requests.

Interestingly only female research participants raised this issue, the restrictions did not seem to apply to the men. The precautions were however taken very seriously by many female attendees.

Many aspects of the daily living experience at the Shrine were considered conducive to healing. The attendees recited verses from the Qur'an, held on to the *jaali*, wore sacred threads, and partook in the distribution of *lungar*. They experienced a purification of the body through the expulsion of bodily fluids and

women took care to draw less attention to themselves as they observed restrictions on their behaviour. The arrival of thousands of pilgrims on auspicious days served to validate and reinforce already strong belief in the power of the Saint to heal and thus kept their hopes alive.

Dedication and commitment to the healing process

The attendees talked about the importance of resigning themselves to the process of healing. There was a strong opinion that those who were prepared to give up their worldly comforts and live at the Shrine would eventually be blessed. Those who returned on special days for prayers and *hazri* talked about how they had modified their lives and integrated the Saint's instructions into their day to day life. Healing was seen in the context of getting relief from their current problem as well as achieving status in the spiritual world.

One attendee, who had been at the Shrine for the last three years, stated that as long as she was alive, she would wait for the Saint's blessing and for the treatment to work. She would then die in peace. For her, and for many others, absolute faith was necessary to be granted healing. A carer (SABIHA) expressed this strong belief and dependence upon the Saint:

'I have 110% belief that it will all work out. From her (*daughter*) behaviour it seems that she has a holy spirit in her which releases a person more easily than the evil ones. But it still all depends upon the *Baaba's* orders.'

For SUBHA, having faith was crucial to healing:

'I told you that I have strong faith in shrines and saints. The main thing is one's faith; if you have faith then you will get healing otherwise there is no use. *Baaba* doesn't give anything physical but if you really believe, you get a lot of spiritual healing'

Apparently negative events were perceived in a positive light by the attendees. Pain, discomfort, and the hardships of living away from home were seen as a test of a person's love for and dedication to the Saint. The 'woman with a veil' who had lived in a tent for the last 3 years gave up her 'normal life' to show her dedication and felt that it had given her eternal happiness.

It was expected that when a person came to the Shrine they had to be open about the time it could take for the treatment to take effect and they should not make plans to return home. Those who wanted to leave after a short period were seen to be lacking in dedication. They were frequently reminded by others that premature departure from the Shrine may have adverse consequences. This put responsibility on the attendee to recognise when it was the right time to leave. If pressurised by others to leave prematurely, it could lead to a relapse or further complications.

FAZAL had removed his daughter from the Shrine before being granted permission as she seemed to have improved somewhat and his financial situation was difficult. His daughter subsequently deteriorated and he regretted his decision:

'I have now become very cautious. No matter what the decision is, whatever it requires, I am ready to do that, I will give any sacrifice it requires. If the *Baaba* doesn't permit us to go, we will stay here.'

SABIHA, a carer was also willing to stay as long as necessary:

'I don't know how much time it will take. But while I am alive, I will be with my son and I have total faith and hope that the *Baaba* will heal him completely.'

Waiting for a *bishaarat* and living in uncertainty was considered the norm in the Shrine community. They sacrificed everything outside in order to participate

in treatment. They had invested a lot and so needed to see it through. ZARA was also prepared for an indefinite stay:

‘It’s all in the hands of *Baaba*, he can cure my problem. I will be well and free from symptoms if I continue to pray and live here and follow the treatment plan *Baaba* suggests...it will all depend on *Baaba*’s instruction. When my condition is good enough to go home, I will go.’

This was echoed by HAMAD:

FP: ‘Do you have any idea when you may be going home?’

HAMAD: (smiles) ‘No, *Baaba* knows these things and he will tell me when it is appropriate.’

FP: ‘Some people here said that they were told about when they could go home.’

HAMAD: ‘Yes maybe when *Baaba* knows that their treatment is complete then he can inform them of their discharge and also when they need to come for follow up.’

The attendees firmly believed that the Saint could only fight for their cause if they kept their promise to follow the plan and obey the instructions given. MUHIB described what would happen if they failed to do so:

‘The influence from the evil or magic becomes stronger. They take complete control of the person and make him do things which are inappropriate. Like swearing, fighting, and all rubbish things.’

A small minority considered deterioration in their condition following premature departure from the Shrine to be a punishment from the Saint. However, the great majority considered it to be the result of the increasing power of the evil spirit which had not been fully overcome. When asked what would happen if she went home without permission TARA stated: ‘I will be punished. *Baaba* will punish me and my illness will become more serious.’

However, SUBHA had a different view:

‘The Saints don’t punish anybody. Their existence is for the welfare of humankind, they don’t punish. However, if people don’t listen to *Baaba*, then the evil or influence inside them can tighten their control over the affected. It is up to an individual whether to obey the Saint or not.’

Faith in the Saint and the process was considered crucial to the healing process. Many sacrifices were made and hardships endured and having an open mind about the length of treatment required was also necessary. Attendees seemed more willing to commit themselves to the uncertainties of the healing regime at the Shrine than they were to medical or other treatment.

Living in a small community

There was a sense of community among all those living at the Shrine. Attendees were mostly aware of each others’ problems and what they were seeking healing for. The concept of boundaries or invasion of personal space was almost non-existent. Often women joined each other during the research interviews without seeming to cause any discomfort or raising objections from the interviewee. They openly offered their advice and shared strategies for dealing with the ‘problem’. In fact, many referred to this source of advice within the Shrine community as an important factor that helped them get better. SEEMA spoke of the supportive relationships she had developed at the Shrine:

‘All these people you see here, we have all travelled together from Makki Shah¹⁹. I know them well and they take care of me when I am not well. From these people I have found brothers, sisters, aunts, and mother, friends, all relations... all day long, when we sit, we talk, we laugh, we eat together, and we pray and recite devotional songs together. It is very helpful for my health.’

¹⁹ The Saint Makki Shah – Another shrine well attended by people, in a different part of the province.

The men seemed to get along easily with other male attendees and went to the nearby town during the day and socialised with shopkeepers.

The social environment of the Shrine also highlighted people's generosity when they distributed meals, utensils, or money to other people as alms. Although a majority of the Shrine attendees were from underprivileged backgrounds and struggled to meet their own needs, food and sweet offerings were regular features at the Shrine.

Being together with others and part of the group was very important for many participants. This was the case for SUBHA:

‘All other people gathered here are also here for healing. When all pray together, there is spiritual environment and that relaxes me greatly’.

MUHIB related how he had been helped by the close relationship he had developed with another attendee:

‘I was unwell...I used to come to the Shrine and spend my time here. There was another revered *buzrug* (old man) who used to spend most of his time in worshipping and prayers. I built a very good relationship with him and we used to talk as well as laugh together. He would see my condition and pray for me. He also took care of me during that time.’

Living together as a group was supportive and encouraged sharing; however, differences of opinion and ways of living also caused arguments. At times disruptive behaviour, loud noise, and interference from other attendees and visitors became a source of friction and led to a negative atmosphere:

‘There are at least 25-30 families living in the Shrine. Many of them have bad influences (*possession*) on them. These influences make people fight with each other. They cause conflicts and arguments. This noise, I find very unpleasant and don't like it. When so many people especially women and children live together obviously there will be some irritations.’ (SUBHA)

INF-F-30 also found other attendees hostile but she blamed their jinn for this negative behaviour:

‘For many months we lived together here but people were not very kind. We were moved from one place to another and they would harass us so that we would leave the place. It is actually not people like the manager or others in authority, who try to bother me it is their jinn....they cause conflict, wind people up and spread chaos.’

For one carer, the lack of privacy was a serious issue:

‘I feel very unhappy, am not sure if this will work out. It is very difficult to live here; there are hardly any facilities for eating, bathing, or toilets. I have also brought a two months old baby who needs my feed.... It is quite embarrassing to be breastfeeding while in such an open space....’ (INF-F-26)

Although many attendees enjoyed new relationships at the Shrine, others remained isolated. People sometimes felt that they were not respected for their age, level of education or socio-economic status. MUHIB disapproved of the behaviour of others and their ignorance of how this affected the healing process:

‘Sometimes people who come to the Shrine lack etiquette. They talk to each other in an impolite manner and harass others. I stay away from these types of people. It is not that coming to the Shrine will make things alright, you have to improve your behaviour also if *Baaba* is to heal you completely, and people don’t understand this.’

Some women felt that living in the Shrine could become very risky if they were not alert to the dangers.

SHAHEENA (SAIMA’s mother), when describing a previous visit said:

‘I used to be so scared in the night when there were thousands of people around and my daughter was lying in a corner with no energy. My

daughter was very pretty and I found people staring at her and that upset me a lot.'

There were subtle hints about sexual advances made by men and fear of abuse. Maintaining self respect was an important consideration for the women staying at the Shrine:

'May Allah help girls in maintaining their respect here. Many males will come and sit around here and you certainly have to be responsible for your own safety. If I call those boys and feed them or accept tea or food from them, it will only encourage them to come again and spend more time. Most of the time I am here, but there will be times when I am not here then who will take care of my daughter, it just ruins the whole environment. Everybody is responsible for their own shame and honour.'(SABIHA)

AKEELA, who was staying at the Shrine on her own felt that she was harassed by others who frequently questioned why she was alone and were suspicious of her motives. However, she still preferred being alone as it seemed less stressful:

'They repeatedly ask me who I have come here with. I tell them that I am on my own, my husband trusts me and I am keeping his trust, but it is difficult for people to even accept a woman on her own travelling... My husband used to worry about me coming on my own but then I told him that I feel so ill here sometimes that I don't move from my bedding for the whole day. If someone accompanies me, then I have to make sure that he/she has had something to eat etc. and I can't have those worries on me.'

Being away from home also meant respite from day to day stressors such as violence, abuse and conflicts and gave people choices about how to live. FARHANA described what sort of life she had outside the Shrine:

‘I was married but I was living the life of a widow... like a widow because I didn’t have any jewellery to wear, nice clothes to put on, something to eat or enjoy. They (*her husband and in-laws*) would not let me eat anything... A time came when I was looking for some work to earn and meanwhile begging to feed my children. It’s like if you don’t work, you don’t eat and stay hungry.’

Participants felt that at the Shrine, they were able to structure their days, and decide whether to socialise or just rest and relax. They achieved a level of control over their lives and a sense of autonomy, something they may not have had at home. In some ways, the Shrine was a sanctuary. Not having ‘permission’ from the Saint to leave justified their remaining at the Shrine where they were relatively safe.

Being part of a supportive group was clearly very important to attendees, being able to share their suffering, being accepted, and helped by others. There were inevitably conflicts and irritations that arose from living together in a confined space, although these were frequently blamed on the jinn and evil influences. For women, there were particular challenges related to safety and honour and the need to protect themselves.

Discomforts and difficulties at the Shrine

Life at the Shrine focused on meeting basic needs for food, water, and shelter, and praying and interacting with the Saint. Some begged for money and depended on *lunghar* and donations and others found menial jobs around the Shrine to be able to survive. TARA described the difficulties in obtaining food:

‘It is so expensive living here. Although *lunghar* is distributed here everyday, it is not necessary that a person will get it. There is only a limited amount of food. So sometimes when we don’t have money, we have to go hungry.’

Staying on a long term basis at the Shrine was not an option for most of the women as financial resources were required to live comfortably.

ZARA, who was staying with her husband and two children, estimated that it cost her for one week, the same as her husband's weekly salary:

'You have to think of money for food, water, cleaning, toilets, bathroom, ice for water, donation for *Baaba* and to buy flowers and sweets for the grave. But you have to do that because it is your treatment.'

Some attendees rented rooms on site so that they could stay permanently at the Shrine rather than travelling back and forth. However, not many people could afford this facility.

Although both medical as well as religious treatment cost money, people were more inclined to pay expenses at the Shrine rather than seemingly 'wasting' it on medication or diagnostic tests for which they could see little benefit.

Many attendees and carers found the physical environment of the Shrine to be physically uncomfortable and difficult to live in. They talked about unhygienic conditions, lack of drinking water, sharing bathrooms and toilet facilities with a large group of people, the intense heat, mosquitoes and insects, and limited physical space to move around in as things which made living at the Shrine very difficult. FARHANA expressed her feeling of discomfort:

'There is great peace here but there is no comfort. For example, if I want to do my prayers, one needs to clean... or change clothes. Here there is no place to wash or clean or change your clothes. If you want to use the bathroom, you have to pay money and it is not possible all the time. This is the biggest downfall of this place.'

This was echoed by RANA:

‘If *Baaba* heals me completely today, I will leave tomorrow. There is no comfort here at all... At least when we are home, we can make ourselves comfortable...the conditions here are very bad. Now if it rains, there will be a thousand types of insects.’

SHAHEENA (SAIMA’s MOTHER), also agreed:

‘...living here is such hard work; the floor is so hard that my back hurts all the time.’

For SADA, it was physically uncomfortable but mentally relaxing:

‘At home I would do some small chore and then take some rest. I would sit on the sofa or lie on my bed or put my feet up. Here, of course I have to lie on a cement floor using my arm as a pillow. A lot of the time, I toss and turn for hours to get into a comfortable position....but mentally, being here is very relaxing and peaceful.’

This feeling of peace despite of physical discomfort was confirmed by SUBHA:

‘If you look at it from the point of physical comforts, then I would say here we have much stress. Of course we have left the comforts of home but here we have peace, much peace. In spite of having everything, we can’t have this sort of peace at home.’

For others, poverty and limited resources, combined with the isolated geographical location of the Shrine, prevented them from keeping close contact with their family members back home. HAMAD rarely saw his family:

‘They used to come frequently before but now the bus fares have gone up. Also if two people come, they pay for fares, plus they bring me something to eat, they eat here or on their way. Sometimes they also leave a bit of cash for me here, it all adds up. I have told them not to bother too often....’

In order to stay at the Shrine on a long term basis, the attendees had to satisfy questions asked by the caretakers about reasons for their stay. Those who managed to satisfactorily answer or keep the management happy, stayed there for a long time while others were forced to move to other shrines. At times families brought gifts for the caretakers so that relatives were left in peace. One woman described how it ‘ripped’ her heart listening to the caretaker chastising poor woman who had run away from home because of domestic violence and was using the Shrine as a refuge.

‘I had witnessed the khadima²⁰ using extremely improper words for attendees and in some instances running after children with a big stick, hitting them for discipline purposes. However she has her own reasons for behaving in certain ways.’ (INF-F-10)

The presence of the khadima was seen as unnecessary and a nuisance by the women participants. They had suspicions that she took bribes from people to let them live in the Shrine and was also involved in some immoral activities (they refused to elaborate on these). This was seen as further evidence of a lack of support and understanding from the Government who had appointed this person.

Many difficulties had to be endured at the Shrine including the behaviour of the caretakers. The isolation location also made it difficult for attendees to keep in touch with their families. Overall, the environment was not a comfortable one, however, despite this; many attendees described feelings of peace and calm that they were not able to achieve elsewhere.

²⁰ Khadima - Female servant – in the context of the Shrine, it was used for the female caretaker

Length of stay and negotiation

The expectation of total dedication to the Saint and the healing process meant that attendees could find themselves committed to an indefinite length of stay. At the time of the data collection the participants had been staying at the Shrine for anything from one week to 21 years. While some attendees considered this uncertainty around length of stay to be part of their treatment and remained positive, others felt extremely frustrated and disappointed especially those who were attending the Shrine for the first time or those who had left young children at home. NAGRI (a carer) felt that while her son found relief from being at the Shrine, others were suffering due to her absence from home:

‘The whole family suffered and is still suffering. I was taking care of my older son and when I went back... my younger son had started moving around in bad company.... For the last three years, I am here and constantly seeking *Baaba*’s help to heal him (*the older son*) but there is no answer. For me...it is the same as living in a prison.’

A few carers described having been at the Shrine for 2-3 years already, without their loved one being healed. However, they were willing to wait as this was the only place where their child’s behaviour could be controlled and they were accepted by others. They seemed to find themselves in a dilemma; if they chose to take their family member back home it disturbed the rest of the family and risked family honour. If they left them at the Shrine, then someone was needed to look after them. Many women, as mothers, expected that they should stay as carers and lived at the Shrine in hardship.

At least two attendees felt very unhappy about being at the Shrine and voiced their doubts about how being there would help. They were uncertain about staying at the Shrine for an indefinite period of time while there were other children at home who were suffering as a result. This discomfort was seen more commonly among those women who had younger children at home, left with

relatives while they waited at the Shrine for healing. NASR faced an acute dilemma, to return home to her children or remain at the Shrine for healing:

‘My children are very young. Just imagine the oldest one is only 12. I worry about them all the time. And then I see my daughter (*the one staying with her*) and I become more stressed because she misses home a lot... My children miss me a lot, but my husband also insists that I have complete treatment before coming home...According to my cousin I should stay here for forty days but I don’t know if I will be able to stay here for so long. The whole family is so disturbed and my little girls at home are so upset. I will pray to God that if he wants, he can heal me at home also. Maybe he will have mercy on me.’

Some attendees appeared to be quite innovative in how they dealt with the issue of indefinite length of stay. They described negotiating with the Saint to allow them a degree of flexibility. SEEMA who was not able to stay at the Shrine in Thatta for an unlimited period was given ‘permission’ to attend another shrine which was in her home town and then make visits to Thatta once a month:

‘After giving birth to my son, *Baaba* shifted me to a shrine which is closer to my house. I went there for my *hazri*, and that is how my condition improved. I now have four children and I am feeling well. I come here every *nochandi* to offer prayers and to stay for a few nights.’

Similarly, some negotiated with the Saint and were sent to different shrines to aid their treatment. HAMAD described this as the Saint as consultant, sending the attendee to different shrines to have consultations with others so that a proper diagnosis could be established.

‘There is a system for healing. It works the same way as you see in hospital. The way a surgeon is the highest authority and all report to him after their assessment, in the same way when a client comes to *Baaba*, he refers him to other saints and their shrines for assessment. All these saints report to *Baaba* and then the treatment plan is drawn up.’

It was also emphasised that when appropriate, the Saint would send them to hospital and dispensaries because the nature of their ailment was different and required a medical approach. During a *hazri* MOOMAL was given the name of the actual hospital where she went and was diagnosed with a gastric ulcer and was treated successfully.

MOADIT described the Saint's flexible approach:

'If he (*the Saint*) feels that he (*the attendee*) cannot be managed at home because the power of evil is too strong, he suggests that the attendee remains at the Shrine. However, if the person is recovered enough or the evil can be controlled outside the premises, the *Baaba* sends his good spirits with the person to protect him outside the Shrine.'

Some were also advised to use a local shrine as a type of day care facility:

'If I go one day, then the next day I am very alert. I take care of my kids, send some to school, give them breakfast, prepare meals in the house, and finish all the household work before midday. Then I leave for the Shrine. If I miss going to the Shrine one day, my next day is completely wasted and spent in bed' (SEEMA)

AKEELA described how she had negotiated the terms of her treatment with the Saint:

'I used to have an open *hazri* initially. The thing inside me used to talk real dirty (*sexual content*) so I requested *Baaba* to change it. I told the *Baaba* that I come to the Shrine on my own and I am from a respectable family. I did not want people to see and hear me like this so please shut his (*the jinn's*) mouth. You can hear whatever he says but please don't let others hear it. Since then I have a '*ghum hazri*.'

Some attendees saw no improvement in their conditions despite a lengthy stay.

TARA stated:

‘I feel so fed up. Despite being at the Shrine for so long, still I have not recovered completely. I do get temporary relief but then this *ghabrahat*, restlessness and distress still goes on. I just want to go home and feel well again.’

AKEELA voiced ambivalent feelings towards the whole phenomenon of healing at the Shrine. She sometimes felt trapped:

‘...although people may find it rude or disrespectful, but I have seen this, and I would say it out loud. Anyone who starts coming here for healing, ends up spending their whole life coming back and forth. His life is then bound here forever.’

Some attendees blamed lack of improvement on their own lack of belief in the Saint and his ability to bless them with healing. The emphasis was on switching one’s mind completely from home worries and bearing pain and suffering to achieve healing.

‘...There are also patients who have been here for years and are still not cured and one of the reasons is that they don’t maintain respect for this place and get involved in other things – moving away from the purpose which has brought them here in the first place. Those who meditate and worship Allah and stay focused are freed quickly.’ (FAZAL)

Many attendees had been at the Shrine for long periods of time and all lived with uncertainties about when they would finally be able to return home. Separation from the rest of the family at home caused pain and hardship. As a response, some had been able to negotiate with the Saint the conditions of their treatment, which made it easier for them. The flexibility of treatment extended to include medical treatment, alternative healing venues, and the type of *hazri* experienced. Although most attendees seemed content to live with the

uncertainty, a few did voice their doubts about the advantages of staying and felt ambivalent about the treatment.

Being at the Shrine against their will

Some attendees were brought to the Shrine against their wishes and forced to remain. These were often younger people who appeared psychotic, were uncontrollable, or were physically or verbally aggressive, sexually disinhibited, or overactive. These people were tied using metal chains or ropes to a metal grill surrounding a grave, located at one corner of the Shrine compound. Some attendees had their feet tied whilst others had all four limbs restrained.

The family members of restrained individuals remained within a few feet and assisted them with their need for food and hygiene. Restraining the person was thought to assist in breaking the evil power and begin the healing process. SABIHA who chained her daughter explained it thus:

‘Some people come and ask me... why is she tied here but then I tell them that she has this problem and that is the reason we have kept her chained. Why else would both of us sit here under such harsh circumstances? Sometimes people see her and make inappropriate comments but they don’t understand what we are going through.’

Family members justified restraining a loved one as a way of preventing them from running away. This was exemplified by the following, told to me by a father (INF-M-27) whose 14 year old son was restrained for several days. The boy was continuously talking to himself, swearing and cried out loudly periodically:

‘About a year back my son started behaving abnormally. He would not get out of bed, won’t wash himself, eat, or do anything. He was scared if there was a little noise and started crying. We thought he is just worried about something and did not pay much attention. But when the situation did not improve, we took him to doctors, the ones who specialise in the brain and also the psychiatrist. He was put on several medications, which

we gave for some time, but there was no improvement, in fact we felt he was deteriorating. He started swearing, using abusive words, and started to hit when we interacted with him. When we had lost all hope, I got a *bishaarat* from *Baaba* to come to the Shrine and stay for seven Thursdays (*seven weeks*). We came here; he was tied to *Baaba Ramzani*²¹ and his condition improved drastically. He came to the same level as before this all started with no medications at all. We stayed for the required period of time and then *Baaba* made us promise that we will come for a day every *nochandi*. We continued our promise and our son remained very well for one whole year. However, for the last two months we missed coming to the Shrine due to our carelessness, he has become unwell again.'

The protests of the restrained person, their pleading, their incontinence, and at times their swearing were seen by relatives as attempts by the jinn to embarrass the whole family so that the person would be released, so freeing the jinn and interrupting the treatment. Once the person agreed to follow the regime and there was a level of calm, the chains were removed.

There were mixed feelings among attendees and carers about restraints and not everybody agreed with it; however there was an agreement that the evil needed to be controlled and that public humiliation or punishment was a form of repentance for previously committed sins or transgressions of societal norms.

Retrospectively, some attendees who had been chained described their experiences as positive and containing. They justified this by describing how the chains actually are restraints applied to the jinn and not the person. There was a

²¹ *Baaba* Ramzani – A Saint whose grave is located at the right hand corner of the Shrine compound. Disruptive, violent or difficult to control attendees were often tied to the metal grill (surrounding the grave), in the belief that this would control the behaviour of the afflicted.

sense of detachment of the illness behaviour from the individual. All the undesired behaviours were assigned to the jinn possessing the person and the affected person was regarded positively and encouraged to be patient and strong in dealing with the crisis.

Effects on carers and others accompanying the sufferer

Many attendees at the Shrine depended greatly on their carers to provide practical help and stay with them for an unlimited time period while they received healing. While for attendees it was often a positive experience to have company and a sense of 'being taken care of', for many carers it meant compromising their responsibilities at home or at paid work. The remaining family members at home often reallocated and shared those responsibilities. Frequently, children took on greater responsibilities such as caring for younger siblings and housekeeping. Often the eldest daughters at home, many still children themselves, left school to take care of the rest of the family.

For some carers, their involvement in caring was total. Nagri (a carer) felt that her son was not safe or able to take care of himself without her help:

'...he roams around outside with bare feet and gets hurt all the time, but he is in such a state that he doesn't have any awareness of what is happening around him. One day I pulled out a small bluish nail from the sole of his left foot. So easily it could have spread poison around his foot, but he was not even aware that it happened. If I don't take care of these things, who else will?'

Some men who stayed with their wives put their jobs or business on hold in order to remain and to protect their 'honour'. There were instances when they expressed resentment at being in this position. However, if the one who was 'unwell' was a daughter, it was absolutely essential that they were not alone left on their own. This created severe strain for some families:

‘Oh child, our home has been *tabah-v-barbaad* (devastated) completely. Her father has ... this worry that what will happen to her once he dies...Who will help her and what will happen to her.’ (RANA’s MOTHER)

Many young children were also staying at the Shrine with their siblings and parents. In one family where an older daughter was ‘unwell’ and her mother had to stay with her, four younger children also stayed as there was nobody at home to look after them. The children observed and participated in healing rituals and appeared extremely comfortable and adjusted to the environment. Some older attendees remembered times when they had accompanied their relatives and stayed at the Shrine for weeks or months.

I observed a young girl J. of about 4 years of age staying at the Shrine with her mother. Her mother said that she came to the Shrine after her husband and in-laws threw her out of the house and refused to take her back. At that time J. was 4 months old, and since then they had been living at the Shrine. J. moved about independently in all parts of the Shrine and interacted with other people. She was the first one to collect any food or any other offerings distributed at the Shrine, and often brought food and drinks for her mother who lay in the female residence hall, with a scarf tied around her forehead.

At times J. told me that attendee A or B is experiencing *Hazri* as she is possessed or under a magic spell. J’s mother was very aware of her movement and kept an eye on her, however, many times while her mother slept, J. roamed around and met other people and talked to them. Considering that each day the Shrine was visited by hundreds of different people from all walks of life, J. was at a very high risk for abuse and exploitation (I witnessed her being shouted at by the food sellers when she asked them to give her some tea). She talked and listened to people with great interest about what lay beyond the four walls of the Shrine.

Being at the Shrine with a loved one had a big impact on carers and other family members staying with them. For mothers, accompanying and caring for a son or daughter could be all-consuming, and for children who had spent most of their lives at the Shrine, safety was compromised and the possible long-term effects unknown.

PATHWAYS TO THE HEALING AT SHRINE

The attendees appeared to follow a variety of pathways to the Shrine. The concepts around healing at the Shrine and the Saint's miraculous healing power were already familiar to most of them. For those who suffered from problems they considered physical illnesses or ailments it was frequently something they considered alongside medical treatment or after medical treatment had failed. For those attendees, who came to the Shrine with a chronic physical problem or a problem they thought related to the supernatural, the Shrine was sometimes the first choice of help.

There were seven identifiably different routes by which attendees appeared to come to the Shrine:

1. *Following failure or fear of medical treatment:* Apparent failure by doctors to diagnose or treat a problem was seen as a sign of supernatural illness. ZARA explained

‘Some people go to a doctor with their problems, get diagnosed, and are prescribed plenty of medications and still their symptoms are not relieved. Then they know that it is not due to a physical problem but due to ‘*asar*’ (*evil influence*) or ‘*amal*²²’ or ‘*saya*²³’ or ‘magic’. So then they come to *Baaba* to seek healing.’

²² Amal - To mutter a spell

²³ Saya - being possessed by an evil spirit

Those who suffered from chronic illness felt that their medications relieved their symptoms by only 50% and they were looking for a total cure. Some reported a miraculous healing at the Shrine and relief from their problem for the first time in their lives. Medication had helped MOOMAL temporarily but coming to the Shrine resolved the problem completely:

‘When I took medications, it would give me temporary relief but with time the problem was getting worse... it never went away until I started coming to the Shrine. Since I have been having my treatment here, there is a difference. Believe me for the last 5-6 years, I have not had a single pill, not even a Dispirin as a painkiller.’

For others, there was fear of the suggested medical intervention. SAREENA was afraid of an operation and hoped that her goitre problem would be resolved at the Shrine:

‘Doctors tell me that I need an operation (*for enlarged goitre*) but I wouldn’t have that. I feel very scared of an operation because it involves my throat – I might die. They said that it is a tumour....It is just all tricks by the jinn; they are circulating in my body and causing problems. That is the reason I have come here so that *Baaba* can help me get rid of this problem...’

When medical treatment failed to produce the desired effect or was considered unattractive, then the problem was reappraised and considered supernatural in origin and sufferers made their way to the Shrine.

2. *An incurable problem diagnosed—the only hope is for a miracle:* One couple, who were informed by their doctor that they could not conceive, started visiting different shrines in the hope that with the Saint’s special healing power, they would be blessed with a child. They were not the only ones who waited for a miracle, a woman with a daughter who had a severe learning disability, waited at the Shrine patiently for the Saint to cure the

problem and make her 'normal enough' so that she could take care of her own needs.

When all else had failed and there was little or no hope for a cure or change in condition, then the Shrine served as the final chance of achieving a miracle.

3. *Referral from faith healers:* Those who had been to local faith healers for healing felt that it was a) not very effective and b) very expensive. In some instances after a long course of treatment with a faith healer, it was suggested that the attendee go to the Shrine as the problem was 'too big' to be treated:

'because it is nothing but magic... I had it (*the problem*) assessed by a faith healer but he couldn't help me... (*he*) asked me to go back to the shrine and I came here.' (MOADIT)

The failure of treatment given by faith healers, as with the failure of medical treatment, also led people to try the Shrine. It seemed that faith healers themselves were happy to refer patients, whom they could not help, directly to the Shrine.

4. *Called by Bishaarat:* A few attendees described that when overwhelmed with problems, they received a *bishaarat* from the Saint asking them to attend the Shrine (several examples have been given earlier in this chapter). These *bishaarat* were in different forms and needed to be interpreted by the attendee or their family members. Rarely, these *bishaarat* were received by the attendees' carers.

These attendees had come directly to the Shrine after receiving the *bishaarat* and did not seem to have tried any other sort of treatment. They had interpreted the symbolic message as a call to Thatta and the Shrine

5. *Self diagnosed supernatural problem:* For those people who had previously visited the Shrine and had a positive experience, when they realised that the problem had re-emerged, they came straightaway to the Shrine:

‘last time her (*daughter*) symptoms subsided completely and she was able to live at home and continue functioning normally... she even took an admission in a flower making course and enrolled for Bachelors studies...during her exams, she became ill again... I knew that the evil has attacked again so I brought her back’ (SHAHEENA, SAIMA’s mother).

Repeat visitors were quick to diagnose the return of a supernatural problem when symptoms reappeared or behaviour deteriorated. Their previous positive experience at the Shrine encouraged a swift return.

6. *Parallel help-seeking – medical help and the Shrine:* Some attendees continued consultations and treatments from both medical and religious sources. They felt that the Saint would make the medications more effective in dealing with the problem or refer them to relevant medical personnel if the nature of the illness was indeed physical. INF- F-02 was using this dual approach to her son’s problems:

‘He is under treatment for cardiac problems, and takes his medicine regularly. One has to have treatment from both sides...it is better to have more treatment than relying on only one’.

In this way, some of the attendees tried to get the best from both worlds and cover all possibilities rather than put all their eggs in one basket as it were. They were able to adopt a multi-treatment approach which they considered most effective.

7. *Shrine as shelter:* There were a few who were staying at the Shrine because they had been evicted from their own homes by their spouses, siblings, or parents. Although none of them acknowledged it, they were effectively

homeless. The Shrine was a place where they could receive some shelter and food. What was not always clear was whether some sort of ailments/illness led to them being evicted or the ailment started after the eviction. The attendees in these cases described problems as magic spells which affected their family members' ability to make rational decisions which was the problem that kept them at the Shrine.

For those left homeless, there was little choice but to come to the Shrine as they had no place to shelter and compared to life on the street the Shrine was relatively safe. Those who used the Shrine as a refuge in this way, may or may not have had a 'problem' as such but identified themselves as a person affected by magic and they were able to justify their stay.

In these different ways, attendees came to view their problems as supernatural in nature and to consider the Shrine as an effective source of healing.

CONCLUSION

The interviews with the research participants, combined with observations and informal conversations with other attendees at the Shrine, provided rich data and insights into their thoughts, beliefs, and everyday lived experience. Attendees explained their problems largely in terms of supernatural phenomena – magic and possession – and the symptoms were physical and emotional or emerged as a series of misfortunes.

The social context of the participants was often one of poverty and adversity and they experienced stigma and exclusion as a result of their problems. This usually contrasted strongly with their experience at the Shrine where they were surrounded by a like-minded community of sufferers.

The everyday living experience of attendees and the Shrine's importance as a sacred place emerged clearly in discussion and a complex relationship and communication between the healer, or saint and the person seeking healing was apparent.

Participants described how they lived in a harsh, uncomfortable environment, endured painful treatment and dealt with uncertainty over the length of time they would need to stay at the Shrine. Although a few came unwillingly, the majority chose to come and stay. Many experienced feelings of great peace, whilst all maintained hope for a full and miraculous recovery.

People came to the Shrine via a number of pathways. Some came directly whilst others had tried other forms of treatment first. When the outcomes of medical diagnosis and treatment were disappointing, supernatural causes for problems were considered or confirmed. Beliefs in the power of the Saint to heal were deeply rooted in family traditions. The phenomena of *bishaarat* and *hazri*, the invisible and visible aspects of the healing process, appeared fundamental in terms of giving control to attendees over treatment and the possibility of exploring a new identity and conferring status upon them.

CHAPTER 6: DISCUSSION

INTRODUCTION

I begin this chapter by briefly comparing findings from the current study with other relevant studies. I then talk in more detail about the explanatory models of the participants in the current study, exploring the notion of possession, its meaning and function and the role that it appeared to play in the lives of the attendees at the Shrine both in the here and now and at a more abstract level.

I then move on to an in-depth look at the place itself, the Shrine, and how the perceptions and beliefs of the attendees fit into the physical and built environment. I then consider the different dimensions of the Shrine, the symbolic landscape and the ambiguities generated within the space and their contribution to the healing process and outcomes. Further, I will consider the Shrine as an alternative healing source alongside locally available biomedical/allopathic health care and treatment and consider the two systems in parallel. The healing power of each system is not appraised or evaluated in terms of efficacy or outcome but the aim is to highlight similarities and differences between the two and consider how these affected their attractiveness to individual participants or their families in a particular socio-cultural or personal context.

Finally the Shrine will be proposed as a therapeutic landscape, where social conditions, human perceptions and the built environment combine to provide a place where healing or transformation is allowed to take place. I describe how the ‘therapeutic landscape’ and the ‘therapeutic landscape experience or encounter’ are related, the specific elements which combine to produce the ‘therapeutic encounter’ and the way in which participants attempt to bring the ‘extraordinary’ therapeutic landscape into their everyday life experience and vice versa.

COMPARISON WITH OTHER STUDIES

There have been very few studies that have been conducted in shrines or temples, similar to this one. However, a number of other studies conducted in the Indian subcontinent or Western studies focusing on people of Pakistani origin have covered relevant aspects. These include exploration of mental health literacy common understandings of the causes of mental ill-health, preferences for type of healing or healers and resulting outcomes. Some previous studies of faith healers are also relevant as are those examining health and help-seeking attitudes and beliefs in a South Asian population. It is, however, important not to confuse studies of faith healers with those conducted at shrines or temples. There are major differences between the two. While faith healers work with clients on a one-to-one basis and sometimes involve the family, healing at a shrine is mostly self-directed and takes place sometimes in the absence of a healer.

Most attendees at the Shrine understood their problems in supernatural terms. This finding is reflected in several studies conducted in India and Pakistan where patients attending a psychiatric facility, shrine or temple have described possession by evil spirits as a cause of their problems (Pfleiderer, 1985 ; Malik and Bokharey, 2001 ; Raguram et al., 2002 ; Padmavati et al., 2005) and alternative healers also shared this belief system (Kleinman and Sung, 1979 ; Gadit, 1997 ; Saeed et al., 2000 ; Gadit and Khalid, 2002) as did health care workers in rural India (Joel et al., 2003). Beliefs about supernatural causes among the research participants were much more prevalent than in some studies looking at beliefs among psychiatric populations using allopathic health systems (Srinivasan and Thara, 2001 ; Mirza et al., 2006). It has been noted in a study in India that when it is believed that a person is possessed, alternative healers are preferred to modern doctors (Kapur, 1975 ; Kleinman and Sung, 1979 ; Saeed et al., 2000 ; Gadit and Khalid, 2002). In the current study attendees were a self-selecting group and having self-diagnosed a case of

possession sought healing at the Shrine. This is likely to explain why beliefs in possession and magic were so common among the participants.

Many participants also expressed their distress through bodily sensations. This is similar to the findings of a study by Pfleiderer (1988), in a Shrine in north east India. Her interviews with women who considered themselves possessed revealed the complexity of the social context in which they lived and how these problems were enacted through their bodies in their descriptions of pain and possession.

In the current study many attendees described how allopathic medicine had failed to bring about improvements in their condition, which is similar to findings from a study in India (Pfleiderer, 1988) and feelings of dissatisfaction with medical services in another Indian study (Padmavati et al., 2005). Contrary to these findings another study (Mirza et al., 2006) conducted in a rural setting in the Punjab, Pakistan, concluded that a majority of people attending a mental health clinic considered GPs rather than religious or alternative healers to be most helpful in terms of treatment outcome. The findings, however, may have been biased by the fact that the interviews were carried out by doctors and psychologists which may have affected respondents' ability to be honest about their opinions, thus offering a more positive view of doctors. In addition, healing places such as shrines or temples were not included as possible choices or sources of healing and so the issue was not addressed.

Significantly, in the current study, several attendees at the Shrine used more than one type of healer or place of healing or tried allopathic and treatment from the Saint simultaneously. This is very similar to findings from a number of studies of South Asian patients living in the UK and in the Indian Subcontinent (Kapur, 1975 ; Tabassum et al., 2000 ; Dein and Sembhi, 2001 ; Khan, 2003 ; Halliburton, 2004).

The study findings most similar to those of the current study come from research conducted at five shrines and temples in India (Padmavati et al., 2005). Although Padmavati's study focussed on attendees who 'appeared to be' schizophrenic, the findings suggested that supernatural causes were the predominant explanatory factor. Temples and shrines were also viewed as readily accessible sources of help. The decision to seek help was made collectively by the family and reflected their explanatory models. The choice of healing venue was affected by perceptions of the type of affliction, local interpretation of illness, the socio-economic status of the sufferer and the availability of healers. The symbolic nature of rituals at the shrines and temples and their perceived meaning, contributed to reaffirming the belief system which had brought them there initially. Similarly in the current study once attendees arrived at the Shrine their belief in the supernatural and the Saint's ability to heal were constantly reaffirmed by other attendees and their everyday experiences within the environment.

Another study (Raguram et al., 2002) exploring the role that a Hindu temple played in improving the mental health of those suffering from particularly schizophrenia and psychotic disorders, identified the importance of the temple in improving mental health without psychotropic medication. Although the participants' perceptions and understanding of the temple stay were not explored, the researchers considered the main contributors to improvements to be the supportive milieu, rest, relaxation and participation in light temple maintenance activities. Similar findings were reported by Hussain et al (2001) in observations at another Pakistani shrine. These descriptions of the positive effects of the environment and of the stay itself are supported by the findings of the current study where attendees also appeared to benefit from a similar regime.

Previous research has identified the reputation of the healer and expectations of healing as key elements of a healing process (Kapur, 1975 ; Henry, 1977).

Similarly at the Shrine there was a strong belief in the spiritual healing power of the dead Saint. His reputed ability to treat and cure, particularly mental health problems, was what brought the majority of attendees to the Shrine. Interestingly, dream interpretations, which Kakar (1982) described as being performed by healers at a temple in India were, in the absence of a ‘living’ healer at the Shrine in the current study, performed by the attendees themselves.

A number of similarities between the findings of previous studies and the current study are evident, especially in terms of the apparent failure of allopathic medicine to bring about sufficient improvement, the therapeutic nature of religious venues and explanations of ill-health in terms of possession and magic. However, the tendency to approach the topic from a Western psychiatric perspective leaves many gaps, including importantly, the omission of the sufferers ‘voice’, which this study has attempted to address. There has also been little or no attention paid to the impact of place on health in temples or shrines in the Indian Subcontinent, and what or how therapeutic experiences or encounters are generated within an environment or landscape.

EXPLANATORY MODEL OF PARTICIPANTS

The current study used Kleinman’s framework for eliciting explanatory models (EM) of sickness from the attendees at the Shrine. Explanatory models are “notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process” (Kleinman, 1980 p. 105) that is, individual patients and practitioners.

The use of an EM framework as an assessment tool has been crucial to the current research as it guided exploration of the problem perceived and experienced by the attendees as well as the social or personal meanings they attached to their experience. It allowed exploration of the health beliefs of people and the linkages they made between their beliefs and behaviours (McSweeney et al., 2007 ; Okello and Neema, 2007). Most importantly it helped

in clarifying the experience of illness from the point of view of those directly affected by it (Weiss, 1997). The flexibility of using open ended questions allowed deeper investigation of significant aspects for each person and their particular social situation. Williams and Healey (2001) suggest that a person's explanation of their problems may not always be coherent and straightforward but involve multiple accounts that are either held simultaneously or taken up and dismissed rapidly. The process of seeking meaning is characterised by "movement and uncertainty" (Williams and Healy, 2001 p. 473) which may not always be negative as the individual tries and discards different identities. This uncertainty is more pronounced among those who have encountered the problem for the first time as they struggle to find meaning of their ill-health or problem. This was certainly also the case for the research participants. Their EMs were constantly changing and being modified and were moulded according to treatment outcomes. I was able to capture multilayered explanations rather than a single causal explanation (Bhui and Bhugra, 2002) that underpinned their help-seeking.

Kleinman's EM is designed for clinicians and I found it very easy when using it to slip into the role of clinician. I therefore had to constantly remind myself that I was not looking at the problem from a clinician's perspective but needed to approach it from a neutral stance and understand the attendees' perception of the problem as it was located in their social world or context.

Unlike EMIC (Weiss, 1997) or SEMI (Mirza et al., 2006) the questions used for the current research used explanatory model questions (Kleinman, 1980) with very little structure in order to allow maximum freedom to the participant to place the emphasis where they deemed appropriate. The next section describes the EMs of the attendees and the meaning and function that this explanation seemed to have.

POSSESSION AND MAGIC

Possession by supernatural forces (jinn or evil spirits) and being the victim of a magic spell were the most common explanations offered by the participants for the cause of their problem. Crabtree (1993) defines possession as “the experience of being taken over by some outside intelligent entity. “Experience” as it is a subjective event, “outside,” as it is interpreted as an invasion by an external being, “entity,” as the intruder is perceived to be having a self-contained existence, “intelligent,” as the action by the entity seems purposeful, planned or thought through” (p.254). Jaado (magic) on the other hand is described by faith healers in a study by Saeed et al (2000) as ‘witchcraft’ or ‘harmful and dangerous black magic’ (p. 482).

In this study both physical pain and mental distress were attributed to possession, the effects on the individual and their families were unique and varied in severity and length of time they suffered with it before considering it a problem. Reports of physical complaints were common and significant pain endured for a long periods of time. Very similar findings were also echoed in a study conducted among Bangladeshi population living in London (Dein et al., 2008). Disequilibrium and disruption in family functioning and threat to family name and prestige, something described by Summerfield (2004) as ‘progressive interruption in social and moral order’ (p. 6) was what drove the attendee and their family to consider options for help seeking. The explanation of the ‘problem’ began to be shaped as they experienced each help resource, whether allopathic or alternative in nature.

The symptoms experienced were commonly perceived to be due to the spirits (mostly evil) moving through the body from head to toe or vice versa and in doing so, affecting different bodily systems. The symptoms were frequently fluid and located in different parts of the body often resulting in long term disability. There existed a belief that evil and supernatural forces were capable of possessing human bodies due to their animosity towards them, and the

justification for this belief was that it was mentioned in the Qur'an (Khalifa and Hardie, 2005).

This belief in possession as an explanation for ill-health and misfortune was similar to findings from a number of studies in different cultures around the world (Prins, 1992 ; Dein et al., 2008). Interestingly, Lambek (1989) notes that possession states are universally common and are accepted by about 90% of the world's population. A study by Kirmayer (1989) in Northern Quebec, Canada also details findings that are very similar to what is described in this study. The existing literature from the Indian subcontinent confirms the presence of possession states among people attending religious or faith healing facilities (Henry, 1977 ; Kakar, 1982 ; Banarjee and Roy, 1988 ; Freed and Freed, 1990 ; Raguram et al., 2002). The belief in supernatural causation of illness also remains firm amongst health professionals in many parts of the world (Joel et al., 2003).

FUNCTIONS OF POSSESSION AND MAGIC

At the Shrine, supernatural theories of causation appeared to serve a number of functions, which are outlined in more detail below.

Justification for poor functioning and deviant behaviour

The behaviours and symptoms described by the participants often marked them out as clearly different within their communities; they were seen as 'tainted' individuals within a tightly knit family and community. Explaining the problems in terms of possession located the problem and any blame attached to it outside of the individual and their family (Lewis, 1971 ; Lambek, 1989). It placed blame on an outsider (jinn), relieving the family from any sense of failure or neglect of responsibilities and allowed them to preserve and maintain their respect and honour to a degree. In many ways, this relieved the sufferer and close family members of feelings of guilt and/or shame in regard to publicly and socially

unacceptable behaviour and failure to fulfil social roles. By locating the responsibility for the problem in a supernatural space, they were removing any need to examine familial contribution to the development or maintenance of the ‘problem’ and any subsequent consideration of the need to make changes to the family unit and the behaviour of its members. The possibility of criticism of the family or any individual was thus removed.

For the individual sufferer, it provided justification for behaving differently or not being in control, thus partially validating their problem. Beliefs about supernatural forces and evil as causes also made it easier for many participants to justify almost any type of symptom or behaviour. Although avoidance and exclusion by other members of the local community occurred, this was perhaps less than what would have been expected had the family or the individual themselves been held responsible for their actions and behaviours.

Indirect pressure on significant others

Lewis (1971, p. 293) suggests that placing responsibility on ‘mysterious forces outside society’ allows the victim of possession to bring indirect pressure to bear on the real target that they are seeking to influence, normally the family. He goes on to say that it is then only through the reaction of other family members and society to the problem that a measure of redress is achieved (this theme is discussed in greater depth in the section ‘Empowerment or total surrender’).

It may also have been beneficial to the family to focus on the outside threat – from an evil force or from magic spells – rather than have to deal with internal, intra-familial conflicts. Having an external enemy or cause to focus on, brought families together to look for a solution to the ‘problem’, it united families when the problem was perceived to be a moral fight between good and evil. Often considerable family resources were mobilised and invested in bringing a sufferer to the Shrine, including accompanying the attendee, rearranging household roles in their absence, and family visits to the attendee undergoing ‘treatment’.

In the cases where attendees were the victim of magic, responsibility for the malevolence was connected to relatives and acquaintances who were thought able to benefit from this disruption (Lewis, 1971 ; Pfleiderer, 1985) and therefore animosity was directed externally rather than internally.

An explanation for the unexplainable

The explanation of illness communicated to a person by the Saint was understood and accepted more readily as it appeared relevant and fitted with their common sense understandings. For example, unexplained pain moving apparently without reason from one part of the body to another was easily understood in terms of magic. It seemed that magic could manifest itself in any way, with or without apparent logic. The ill-logicality of magic seemed to conversely make a wide range of symptoms logical as almost anything could be explained as the result of a magic spell cast by another. Defining the cause of the 'problem' as supernatural was the same as saying that it was 'unknowable', beyond a reasonable 'natural' explanation and therefore removed the need for any 'rationality' in terms of cause and effect. This in turn made it easier for the family to explain and justify the poor or low-level functioning of an individual member and the sometimes extremely deviant behaviour, transgressing societal norms that they displayed. It also appeared to make it easier to explain previous treatment failures.

Hand in hand with this magical explanation of ill-health went the magical belief of a transformational cure or resolution of the problem as the 'bad' magic/evil was driven out. In this way, hope at the Shrine remained alive even over many years, as a miraculous cure for anything could arrive almost at any time and without warning.

POSSESSION AND MAGIC - RELATIONSHIP WITH OPPRESSION

Incidences of witchcraft and possession commonly affect women and some depressed and low status categories of men as well as people of either sex with a social disability (Lewis, 1971 ; Freed and Freed, 1990). It is also noted by Lewis (1971), that among low status and low caste individuals deprivation, frustration, and discontent play a role in making them more prone to possession, especially when the treatment brings special consideration or privileges, and an enhancement in social position, no matter how temporary that is. He calls this phenomenon 'peripheral possession' (p. 294) as he considered this category of people to be at existing on the periphery of society.

The jinn in the current study could be seen as a manifestation or representation of the oppression and abuse that female attendees in particular often suffered in their everyday lives and for male attendees who were in largely subordinate roles at home and were low status individuals. At the Shrine, once a person had been declared to be 'possessed' all behavioural deviance was seen in the light of that 'possession'. For the attendees, all expressions of distress seemed to be completely acceptable and were even encouraged and admired, conferring a certain status upon the individual. During the process of *hazri*, there was an increased intensity of behaviour. This often appeared to be a highly emotional performance. All the extreme behaviours were tolerated and modifications made in the family in order to accommodate the attendees' needs. Women raised their visibility and highlighted their individual needs. This was a way of changing family dynamics. For an oppressed individual within the family who experienced little authority and ability to change, it was clearly an important mechanism for drawing attention to individual needs and concerns without seeming to confront the family head on.

The participants in the study by Dein et al (2008) highlighted the theme of powerlessness among first and second generation Bangladeshis living in east London. They reported experiencing health problems (both physical and

mental) and perceived the cause of this to be the influence of or possession by jinn or other supernatural beings. Despite living in the country for over a decade, they experienced racism, felt misunderstood and not taken seriously by their doctors, and perceived themselves to have no external control over their lives (Dein et al., 2008).

Among the BaVenda people of southern Africa married women who are said to be tormented by mischievous spirits (Lewis, 1971) may be 'diagnosed' as being possessed. Treatment for this requires a de-possession ceremony. At the end of the ceremony, the woman falls to the ground and speaks in the voice of the spirit, informing observers how she entered the body of the sufferer. The spirit also makes demands for items such as ornaments or clothes, which are given to the woman (as a vessel for the spirit) by her husband. The woman then begins to recover, however, she regularly experiences further attacks of possession and more dance ceremonies are performed. Each time she receives gifts and recovers. Lewis (1971, pg. 296) calls this a 'culturally acceptable mystically couched feminist movement' which is used by oppressed wives in male dominated societies. This phenomenon seemed to be very successful for the women in terms of receiving attention and regard from their husbands especially at times of discontent or stress.

Chandrasheker (1989) suggests that possession is exhibited by oppressed individuals who assume a sick role in an attempt to gain attention. The Whitwell and Barker study (1980) which focused on adolescents, found possession states more likely among people with confused and conflicted family relationships where they found it difficult to assert their independence and identity, and deal with sexual anxiety. The findings of these studies are very relevant to the female participants in the current study where they generally lived with rigid moral regulation and were expected to hold and maintain the family honour. For many women in Pakistan, being brought up in a society where women's life begins with them feeling uninvited and unwelcome by their families, married at a very

early age and expected to be subordinate to their husband and his family, does not allow them to develop their individual identity and place in society (Winkvist and Akhtar, 2000).

The experience for attendees however, seemed to be about more than just gaining attention as suggested by Lewis (1971). Being healed at the Shrine brought quite a dramatic shift in power and dynamics within the family; although this may have only been temporary (the shift of power will be discussed in detail later in the chapter). They also gained a ‘voice’ – sometimes for the first time. The inability to verify the presence of possessing bodies using modern techniques (Keller 2002), perceptions concerning the power of the supernatural being and its acceptability in Pakistani culture, played an important role in manoeuvring gender relationships and power.

SUPERNATURAL POSSESSION AND STIGMA

Attributing the problem to magic and to supernatural causation also had a significant impact on stigma for the individuals and their family members.

All the participants in the current research experienced stigma when they failed to meet normative social expectations. The participants expressing somatic symptoms initially received more sympathy and attention from their families as well as from medical practitioners. These findings are similar to those emanating from studies conducted in South India (Raguram et al., 1996 ; Raguram and Weiss, 2004 ; Lauber and Rossler, 2007 ; Suhail, 2007) where lower stigma scores for somatic symptoms were reported. In the current study, those with depressive symptoms such as lack of interest, energy and concentration were blamed for being lazy, while those with psychotic symptoms invited a great deal of distancing and discrimination from neighbours and society in general. They described being ridiculed, and looked down upon by their own family members and wider family networks. They reported being shunned, and not invited to important community and family occasions.

In a collectivist society (Triandis, 2001) like Pakistan, stigma not only affects the individual sufferer but also the whole family and its reputation. Social disapproval or devaluation were considered predominant expressions of stigma experienced by participants in a studies in India (Raguram and Weiss, 2004 ; Suhail, 2005). Similar expressions of stigma such as unwillingness to interact with the mentally ill and discouraging children from speaking to them (identical to findings from the current study) were highlighted in a study exploring attitudes towards the mentally ill among Pakistani people living in Sheffield, England. This reflected an internalised belief and was not necessarily related to educational and social background (Tabassum et al., 2000). Close family members of the participants in the current study were often stigmatised and many experienced difficulty arranging marriages or acquiring jobs as the family carried with it the negative and stigmatising reputation of ‘madness’.

Seeking help can on the one hand bring relief to a person as it removes her/him from a stressful situation; on the other hand it can also make things worse as it is publicly confirms that the problem exists. A matter that had been an issue of “private experience of self” (Goffman, 1961 p. 124) now comes out into the open, affecting individual and familial reputation and prestige. The Shrine provided participants a concealing place, where the person did not have to experience the same level of stigma and social distancing as they were understood and accepted without threatening or risking family honour. They also found a place where odd and bizarre behaviour was quite openly expressed and accepted.

Levels of stigmatisation were further mitigated to a degree once the problem had been redefined or reclassified as ‘possession’ or ‘magic’ by the sufferer or their carers/family members. As the source of the problem was located externally rather than within the family’s control, societal reactions were consequently more understanding, sympathetic, and forgiving.

POSSESSION IN THE LIGHT OF ISLAM - LEGITIMATE OR MISINTERPRETED

The participants in the study justified their belief in possession with frequent references to the Qur'an which they said confirmed the existence of jinn. It is apparent that the issue of jinn has been discussed in a number of chapters of the Qur'an (Khalifa and Hardie, 2005) as creatures living in a parallel world (Werbner, 2003). Reza (2003) and Younis (2000) noted, however, that there is no evidence in the Qur'an to suggest that jinn are capable of possessing human beings or causing mental ailments although contradicted by Khalifa and Hardie (2005). What the Qur'an does highlight is that similar to human beings, jinn are also Allah's creations who are meant to serve Him. While there are some Qur'anic verses which suggest that the jinn try their utmost to deceive human beings and attack them (Al-Ashqar, 1998) the ability of jinn to actually cause mental disorder through entering the body has been considered to be based on anecdotal evidence only (Younis, 2000). Beliefs around exorcism, ancestor worship, charms or the supernatural powers of some individuals who can cast magic spells or haunt others or have second sight are also commonly prevalent in Pakistani society, although these have no authentic basis in the Qur'an (Saeed et al., 2000). Farooqi, (2007) suggests these beliefs result from the impact of Hinduism on Pakistani Muslim society, a lack of understanding of Islamic principles and low literacy rates. In the light of varying opinions emerging from different religious texts and interpretations, it is easy for those not well-versed in the Qur'an and issues related to translations from the original Arabic to develop misconceptions (Nurbakhsh, 1978 ; 1978).

Religion, however, is cited in order to afford legitimacy to the beliefs expressed and is necessary for Shrine attendees; otherwise the system of healing would be considered blasphemous and disallowed. It is interesting to note that the foundation of the belief system would probably not stand up to the scrutiny of Islamic scholars. The basic foundations of beliefs about the whole system of healing at the Shrine could be seen, therefore, as a 'creation' of the actors

participating in it. The beliefs, about magic, jinn, and possession, arise from a narrative which is passed from generation to generation; religious legitimacy is assumed and not questioned by a largely illiterate population.

In Pakistan, religion is very important in assigning legitimacy to activities. Even the suggestion that something is un-Islamic applies a negative label and is stigmatising. It was therefore very important that the concepts of possession and the healing process at the Shrine were both assigned religious legitimacy.

Supernatural explanations appeared to be used by attendees and their families to justify poor levels of functioning and a failure to perform expected societal roles, as well as clearly deviant behaviour. The use of this EM also seemed to allow sufferers to place indirect pressure on significant others, usually family members and to explain that which was difficult if not impossible for them to explain otherwise. Possession as an explanation for problems was grounded in a patriarchal system where direct confrontation of the powerful by women and weaker males was unacceptable. The Shrine served to conceal embarrassing and stigmatised individuals from their communities. Alongside this the very nature of the explanation appeared to reduce levels of stigma particularly within, but also outside, the Shrine. By citing verses of the Qur'an as the basis for beliefs in jinn and the supernatural, religious legitimacy for this type of healing was assumed, although there was no real evidence of a religious or Islamic underpinning of the belief. The Qur'an does describe Allah as the protector of humankind particularly at times when they are being tempted by *shaytan* (the devil) (verses VII: 130, VII: 38, VII: 179, XI: 119, XXXII: 13, XXVII: 17, XXXIV: 12, VI: 112). However, no overt connection is made between jinn and mental illness or mental health problems (Reza, 2003).

THE PLACE – THE SHRINE AND THE AMBIGUITIES WITHIN

The following section attempts to critically examine the micro processes occurring within the Shrine setting. In doing so, providing glimpses into the world of the participants through their lived experience. This experience to the participants, made sense, appeared logical, and explained the illness in a context that was familiar and known to them.

The Shrine was a clearly demarcated geographical space with both outer and inner boundaries, being a distinct walled compound containing a designated sacred space within. It presented a variety of possibilities or experiences not all of which were necessarily positive and the Shrine as a place of healing was itself full of contradictions. Eade (1992) points out that Lourdes is a complex little world where ‘dissonance, ambiguity, and conflict’ can all be found (p. 31). During the study, through the stories of attendees and my own observations, a number of contradictions and ambiguities at the Shrine became apparent. Figure 1 summarises these contradictions and ambiguities and the following section goes on to describe and explore them in more detail and consider how they related to the healing process at the Shrine.

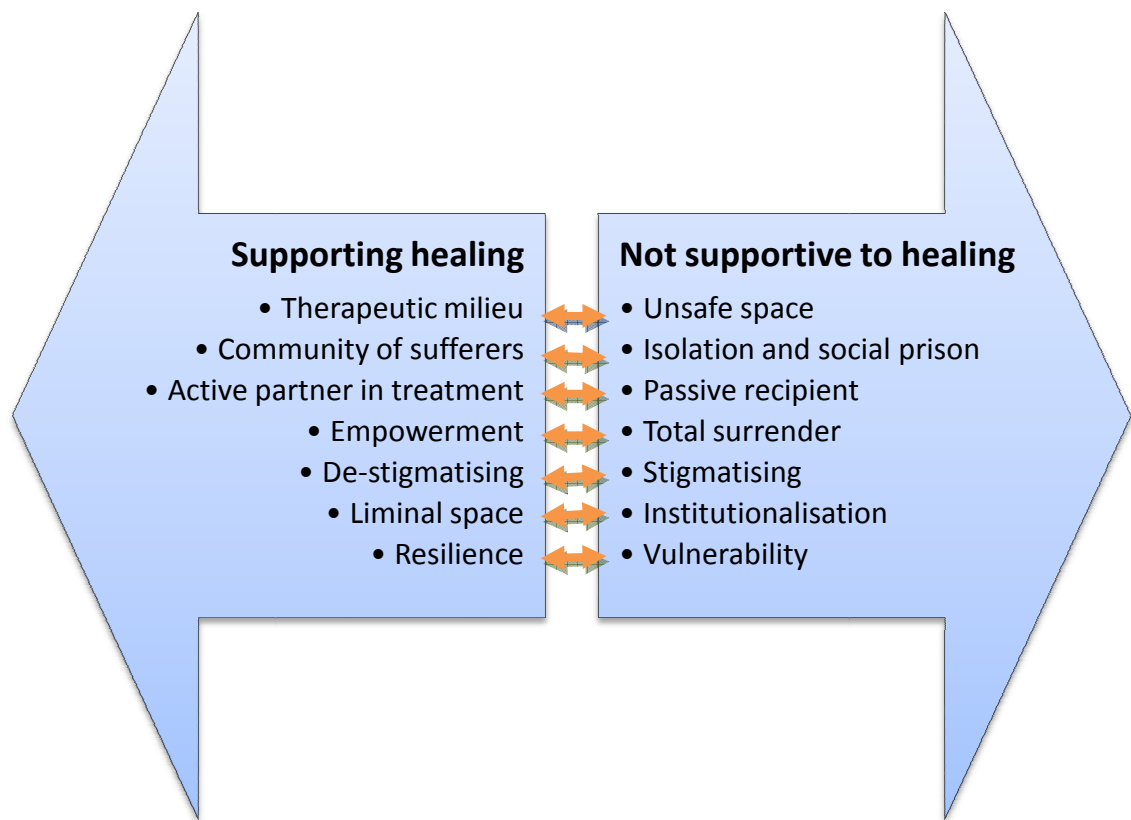


Figure 1: Contradictions and ambiguities at the Shrine

THERAPEUTIC MILIEU OR UNSAFE ENVIRONMENT

The Shrine offered the opportunity for attendees to construct the experience they wished to have. There was no formal treatment structure in place. Attending to personal hygiene, eating, praying, socialising, and interacting with others, was not obligatory and was left to the discretion of attendees. Crying, isolating, pacing, talking to self and screaming/wailing were all accepted as permissible expressions of distress. These behaviours can be considered cathartic. Catharsis is identified as a tool to achieve mental well being and mental clarity. Situations where an individual can physically discharge emotions like anger, grief, and fear safely with the knowledge that there exists a level of control (which will help them return to the present and not leave them in the past) are very important. Catharsis is considered as “a necessary emotion for therapeutic change” (Scheff, 1979 pp. 13-14). The daily interaction with the Saint

in the form of *bishaarat* and *hazri*, which sometimes went on for hours and included screaming, shouting and open expression of distress, seemed to have helped the attendees engage in the process of catharsis, hence releasing 'repressed emotions'. The attendees considered these expressions helpful. The Shrine acted as a space that contained distressing emotions, encouraged catharsis and allowed time to heal. Similarly, a study by Hussain et al (2001) conducted in a number of shrines in Pakistan also found the act of submission and trance, musical offerings, crying and weeping, free expression of emotions, and requests for support and guidance from peers appeared to have a therapeutic effect on the mental health of attendees.

What was significant for all the attendees but difficult for outsiders to understand was the healing nature of the relationship that they developed and maintained with the spirit of the Saint. The relationship attendees felt provided them with hope, protection, comfort, and a sense of being taken care of. Both expectancy among those seeking healing and the reputation of healer or the healing venue were significant factors in the healing process (Thacore, 1978 ; Wirth, 1995)

Those suffering from chronic illnesses displaying 'odd' and 'eccentric' behaviours or severe learning disability found living at the Shrine a way of managing their problem (this was recognised by observers but not the attendees themselves). For attendees, the environment provided them with shelter, food, and affection from visitors, and a social network that appeared to help. Participating in small chores for the good of the Shrine, praying, and structuring their days around the rhythm of the Shrine became both a way of living and of managing illness (Halliburton, 2003). Along with this, the possibility of meeting new people/visitors who regularly came to the Shrine, provided social opportunities and the chance to develop new relationships. The Shrine in this study provided a therapeutic milieu where people were accepted and their cultural beliefs concerning their well-being (physical, psychological, spiritual

and related to the supernatural world) were integrated into their living and healing experiences (Williams, 1998).

Depressive illness and anxiety states can be seen as self-limiting disorders which remit over time, aided by a change in the precipitating trigger, environment, and social situation (Tennant et al., 1982). Living in the Shrine provided the attendees with an environment that was free from their usual home stressors, removed expectations associated with their roles in their household and helped them adopt new coping strategies like frequent prayers, socialising with people sharing similar experiences and self reliance for day-to-day decision making. Prayers and using religious coping to deal with sadness was also common among Muslims in a study conducted in the UK (Cinnirella and Loewenthal, 1999 ; Loewenthal et al., 2001).

Symbolic rituals such as cleansing activities, wearing jewellery as a form of security and protection from evil spirits, drinking holy water and eating flower petals were perceived as daily medicine which enhanced participants' sense of well-being and recovery and worked in conjunction with the changes that were taking place in the family dynamics.

Despite the physical discomforts experienced at the Shrine and the inconvenience of being away from home, the process was often perceived as pleasant and positive (Halliburton, 2003). The radical change in their living experience also changed the focus of their lives from others (their spouses, children, and wider extended family) to themselves. It gave them permission to focus exclusively upon the self, reflect on their life, and find ways of alleviating their pain and distress.

Conversely there was a lack of infrastructure, governance, and/or monitoring of activities that also made the Shrine a potentially hazardous place for vulnerable adults and children. Distressed women, young children, older people, and troubled men were living under the same roof without security or systems in

place to protect and ensure their safety. Attendees moved around in deserted parts of the Shrine without necessarily being aware of the dangers and thus risked their personal safety. Considering that physical and sexual abuse is very prevalent in Pakistan (Douki et al., 2003 ; Niaz, 2003 ; Hassan et al., 2007 ; Rabbani et al., 2008) its possible occurrence at the Shrine cannot be eliminated. Experiences of theft and sexual harassment were verbalised by some attendees as a common problem that they encountered but felt helpless to do anything about.

Having a male member of the family as an escort, provided women (both single and married) with a level of security and safety (Khan, 1999 ; Hassan et al., 2007 ; Hussain and Khan, 2008) and was seen by many women and carers as essential as it protected their honour and respect. Despite living in an environment which could be unsafe and risky, one factor that appeared to protect the attendees from harassment and abuse by others was their public declaration of 'possession states' during *hazri*. The behaviour exhibited during an 'open *hazri*' was the most obvious outward expression of the state of being possessed by a jinn or evil forces, often occurring in front of an audience (other attendees and visitors). Being 'possessed' conferred a level of protection as the 'possessed person' experienced less interference or harassment from others. The dramatic outward expression of the '*hazri*' conveyed a strong message to others to keep their distance, creating a certain amount of fear and/or awe which provided a protective space around them and preserved the integrity of the sufferer.

In addition, there were also a significant minority of attendees who had been brought to the Shrine by their family members, against their will. They were frequently restrained, tied to railings to prevent them running away and as a result experienced public humiliation. There were also periods when they were left alone tied to the place, which was potentially hazardous in case of fire. They

were forced to endure physical hardship, combined with a restriction of movement.

Some attendees experienced a significant change in their perspective, all life events and stress reactions were seen in supernatural terms and at times genuine resources for help were rejected, for example, for obvious conditions that would have benefitted from medical interventions such as epilepsy and goitres.

A COMMUNITY OF SUFFERERS OR ISOLATION FROM NORMATIVE SOCIETY

The collective, communal living experience at the Shrine seemed to play a crucial role in the participants' perceptions of their well-being and healing experience. The opportunity to discuss their life stories and distress narratives with others and learning from each other appeared to work as a form of group therapy. Discussions of their ailments, offering and receiving suggestions of help and support from other attendees made the participants feel an active part not only of their own treatment or healing but also that of others. It appeared to give them the feeling that they were being 'taken care of' as well as 'taking care' of others as they shared their life with each other (cooking, eating *lunghar*, supporting each other during *hazri* etc.). Halliburton (2003) emphasised that the sense of 'being taken care of' may be very important and a therapy that feels good might have benefits over a therapy that feels bad, especially for a problem which is psychological or spiritual in nature. In addition, a choice of therapy can be made on the basis that it is felt to be more pleasant or less painful or unpleasant to undergo than others.

The communal aspect also played a significant role in healing by encouraging people to participate in activities which they otherwise would not engage in, even when encouraged by the family members at home. Similar findings have

also been reported by Martin et al (2005). Many women found, probably for the first time in their lives that they could manage and contain their distress in the Shrine environment, develop supportive relationships with others and learn new coping strategies. This sense of empowerment liberated them and in turn maximised their functional abilities.

The “informal networks of equals” described by Goffman (1968 p. 19) were evident in the Shrine. The attendees served as an audience for each other and offered up tales that supported themselves and others. Most of these tales of miracles appeared thin on facts or clear evidence but were convincing enough to those eager to hear and believe them. Regardless of the authenticity of the tale and absence of objective reality in the anecdotes, the place offered the opportunity for sharing and being heard by other sufferers, usually without being judged or confronted.

Turner (1969) considers ‘communitas’ to be the characteristic of people experiencing liminality together. It takes the group to a higher level and allows it to share a common experience, through ‘rite of passage’. Eade (1992) however, in his study of pilgrims and tourists at Lourdes suggested that there was of a lack of what Turner terms ‘communitas’. He suggested that amongst visitors there were many different constructions of the ‘essential message of Lourdes’ and although there were elements of ‘communitas’, these were only part of ‘a complex contestation of meanings’ (p. 30). The attendees at the Shrine however were unequivocal in their underlying beliefs about the Shrine and the Saint. Even the caretaker, who expressed doubts about the motives of many of the female attendees (at the time he feared his son was planning to run away with one of the female attendees), believed in magic and possession as the causes of the problems of ‘genuine’ sufferers coming to the Shrine. The ‘essence’ of the Shrine was almost completely uncontested. However, on another level there lay ‘a more complex world of dissonance, ambiguity, and conflict’ (Eade, 1992 p. 31).

The Shrine undoubtedly removed attendees from their normal home environment, sometimes for many years. This could be considered exclusion or exile from everyday life and expectations. Sometimes this caused great hardship for the families left behind and had unknown consequences for those children who lived at the Shrine with their unwell mothers and had never known a life outside the boundaries of the Shrine.

For some attendees the Shrine was effectively a social prison where they suffered isolation and punishment (Malik and Bokharey, 2001). Some of those living at the Shrine willingly, also felt that at times they were prisoners as they were isolated from so called 'normal society'. However, there was also an acknowledgement by these attendees, at a later stage, that the Shrine was the only place where they felt that healing was possible and they therefore chose to be in 'prison' in preference to living outside where suffering was considered unbearable. Some who had been restrained during the early stages of their stay later described that they had felt contained as their jinn was under control – the restraint prevented them from doing things that they might have later regretted. In my experience as a nurse in Pakistan, health professionals and the general public stigmatise those who choose this form of help-seeking and often view them with pity and sympathy as they are perceived to be 'isolated' and 'imprisoned' mostly against their will. However, this view was not entirely shared by those who experienced it.

One group of people who did experience the Shrine as a social prison were the long term carers (mostly older women with adult sons or daughters). For them, their lives were dedicated to looking after their children and they suffered from the isolation and hardship. However, for women who were widowed or divorced, with their son and breadwinner being ill, they had better chances of finding a roof over their heads and food at the Shrine than they would in the community where their survival was more problematic.

ACTIVE PARTNERS IN TREATMENT OR PASSIVE RECIPIENTS

The treatment and healing process at the Shrine was completely engaging and involving. This was very different from the attendees' experiences of allopathic medicine where the treatment offered (mainly medication and ECT) did not give them a sense of being engaged in the healing process, was frequently difficult to make sense of, little explained and at times frightening. User groups, self help groups and psycho-education groups are unheard of in the Pakistan mental health system.

Carrying out rituals at the Shrine provided a break for attendees' from day to day home stressors and brought a new structure and routine to their lives. Each ritual activity was aimed at recovery and improving their health. This gave the individual feeling that s/he was doing something to combat the illness, which in itself was important. Food offered to others by the attendee or their family members became a collective effort to enhance well-being. Puja²⁴ and the distribution of food reinforces and redresses bonds between family members thus bringing the family closer together (Henry, 1977). This process was apparent at the Shrine.

The process of treatment in hospital or a clinic often excludes patients from decision making based on the assumption that they will not be able to understand (Thaver et al., 1998). Attendees and families who had used medical help refrained from asking questions as they felt intimidated by the environment and attitude of practitioners who were often overburdened and in a hurry. This is something I have also observed in my professional experience in Pakistan. The language used to describe the medical problem and suggested treatment (if discussed at all) was perceived as alien. The participants had little

²⁴ Puja - religious ritual performed by Hindus on a variety of occasions to pray, show respect to God and seek healing

understanding of the diagnoses made, treatment plans, or referrals, something which has been discussed by Siddiqi et al (2001).

Experiences of *bishaarat* from the Saint and *hazri* appeared to validate the problem as one that was genuine and in need of intervention or treatment. Naming the problem in this way has been considered the first stage in the treatment process (Henry, 1977). The individual structured their daily routine at the Shrine and had power over decisions related to their own care. In hospitals the focus is on accepting the diagnosis of a mental health problem, accepting and complying with medication, and allowing time for it to work. At the Shrine, self-directed healing seemed to have helped them adopt different ways of coping, develop an insight into their problems, and devise strategies to deal with it, with the support of the Saint, and other attendees who formed a type of self-help group.

It is clear from the data analysis that the process of treatment usually included the sufferer throughout as it was the attendee who communicated the treatment, the duration, and what the likely outcome would be, to the external world. The position of the attendee in this process can be seen as inclusive and empowering. Those participants who became frustrated with the process were those who were impatient, waiting for the Saint to improve their situation and did not perceive themselves to be capable of influencing the outcomes of treatment or changing their lives. There was a feeling amongst most attendees that a miracle would not just happen, you had to make it happen through, for example, prayers and rituals. In Pfleiderer's (2006) study of a shrine in northern India significant dreams were reported by attendees to the 'mujavers' (shrine caretakers/guides) who made interpretations of them. She refers to this process of dream interpretation as 'dream work'. The author reports very similar symbolic interpretations to that found in the current study. For example, a dream about a train journey suggested that recovery was complete and it was time to go home. The difference was, however, that in the current study dream

interpretations or determining the *bishaarat* were carried out by the attendees themselves and not by a caretaker or guide. This suggests that attendees in this study held even greater levels of power as the sole interpreters of these ‘dream’ or *bishaarat*.

While in Western society, home represents ‘functional independence’ (Martin et al., 2005 p. 17), for the attendees in the current study their homes and hospitals were perceived to be disabling as they either froze them in a state of distress or progressively worsened their situation. Functional independence includes a person’s ability to make decisions concerning their health and having a level of control over their activities. Taking into consideration the context of the living situation for many participants, ‘home’ did not always represent a place of choice as they experienced oppression, social disadvantage, violence, and domination by others in power. At home there were rigid expectations concerning behaviour and expression of distress and they had little power over decision-making and help-seeking. Conversely, they found the Shrine to be enabling and empowering. At the Shrine these expectations were turned on their head. Dramatic outward displays of emotion were encouraged and decision-making and outcome placed in the hands of the sufferer.

The downside to this functional independence and inclusive approach at the Shrine was that it left the person prone to abuse and being misled. Due to high levels of suggestibility, a person could be persuaded to interpret events in a certain manner leading to physical or financial abuse. Some examples of this abuse included paying large sums of money for donations and/or distributions among the poor, or disengagement from ongoing medical treatment leading to adverse consequences (stopping antiepileptic medications for example). There was also a concentration of businesses located near the Shrine where faith healers claimed to be able to provide miracle treatments and recovery at a price.

EMPOWERMENT OR TOTAL SURRENDER

Wallerstein & Bernstein (1988, p. 380) refer to empowerment as a “social action process that promotes participation of people, organisations, and communities in gaining control over their lives in their community and larger society.” A large majority of the participants found the experience and process of attendance and treatment at the Shrine an empowering one. In order to understand this process of empowerment, it is important to consider the prevailing health care system operating in Pakistan and the options and services available to the research participants in their local communities (discussed in chapter 2). Decisions about individual’s health and help-seeking were made by the head of the family (mostly men), but did not necessarily involve the person suffering from the problem (Khan, 1999 ; Mumtaz et al., 2003)

At the Shrine, communication with the dead Saint was at the heart of the therapeutic process for attendees and the interaction between the individual and the Saint offered a high level of control to the attendee and/or sometimes their main carer. The ‘therapist’, if that title is an appropriate one, was an invisible long dead Sufi Saint whose ‘therapy’ or communication with the attendee was known only to them. The very private nature of consultations with the Saint (consisting of *hazri* and *bishaarat*) meant that ‘instructions’ or ‘prescriptions’ were known only to the ‘patient’. The *bishaarat* was the transfer of messages or guidance presumed to be from the Saint in the form of symbols usually delivered through dreams or during a trance-like state. The interpretation of the symbol was at the complete discretion of the attendee. For those looking for a sign that their treatment was over and that they could go home, a dream of a bus could be enough for them to interpret it as the time for discharge, whereas seeing sad faces of the family members in a dream suggested that going home would have an adverse effect.

Usually, only the attendee was party to these messages and was the only link between the Saint and the family. The sufferer or attendee could not be

challenged in respect of the information they chose to share with their family members. Only treatment which was ultimately acceptable to the attendee needed to be followed. The individual choice was then given legitimacy by saying it was an instruction from the Saint. The relaying of the message or *bishaarat* from the Saint gave public permission to stay or to go and this could not be questioned by family members or others.

This apparent level of control and empowerment was in complete contrast to their previous experiences of or encounters with psychiatric or medical help, where the inclusion of the patient in decision-making and communication about their treatment was completely arbitrary. In this sense the Shrine and treatment at the Shrine could be what the attendee wanted it to be. If at some level they wanted to stay at the Shrine, they could interpret or convey that message with the supporting authority of the Saint and they could not be challenged. Their own voice may not have been heard before, however, the sanction or blessing of the Saint gave power to the attendee's voice and thus was empowering.

The way in which possession was perceived and treated at the Shrine allowed a shift of power from the powerful decision maker to the 'peripherally possessed' (Lewis, 1971), formerly powerless individuals. Female attendees, by being possessed, gained control over their treatment and their lives, at that time. Male attendees, unable to meet societal and familial expectations found justification for this inadequacy and those families who were ostracised by their communities due to 'embarrassing ailments' were able to change their social identities.

Perceptions of control and dynamics of power

The apparent level of control that participants experienced, however, was not openly expressed and in fact was frequently contradicted by comments they made to me. Attendees often stated that they were handing over all control to the Saint and He would decide their fate, how long they should stay and what

they should do. Attendees often waited for many years for a 'sign' that they could leave. They believed that they as individuals had no control over the final outcome and waited patiently for a miracle. However, this type of positioning effectively took away power and control from the wider family unit and particularly from dominant male members who up until this point usually exercised control over decision making. The final outcome of treatment and the length of time required to achieve recovery was in the hands of the Saint. It could be said that this effectively masked a shift of power and control from the family to the individual sufferer. Although not a conscious act, locating power and control with the 'unknown' and 'unknowable' Saint served to allow the individual (often female) sufferer to take some control over decisions about their own life and health covertly but at the same time legitimately. Thus indirect pressure was exerted on significant others to change.

The family did not challenge the validity of the experience and went along with the power shift. The mysticism and fear surrounding possession may also have contributed to making it difficult for family members to challenge the process. They colluded with the explanation as it was beneficial to them, in many ways culturally acceptable and ultimately face-saving. It changed the locus of decision-making control without on the surface appearing to do so.

This could be seen as a form of 'patriarchal bargaining' (Kandiyoti, 1988). Patriarchal bargaining represents a compromise whereby both genders try to accommodate the rules and go along with them and yet may from time to time contest, renegotiate, and redefine the rules and scripts. These patriarchal bargains influence women's active or potential resistance in the face of their oppression and may change over time as relationships between genders are renegotiated and redefined (Kandiyoti, 1988).

Taking responsibility

The healing process at the Shrine gave the participants control over treatment decisions and the belief that treatment failures could be overcome by greater personal effort and the investment of more time and energy in prayer and activities around the Shrine. Interestingly, the attendees seemed content to take some responsibility particularly for the failure of treatment at the Shrine and none of the participants blamed the Saint for treatment failures, quite unlike their view of allopathic practitioners and lack of improvement from allopathic treatment. Their explanations of their behaviour and problems (as the consequence of possession by evil or magic spells) however, showed a reluctance to take responsibility for actions and behaviour that was often forbidden by society. However, it must be remembered that the consequences of accepting responsibility for such actions (those that transgressed social and cultural norms) could be extremely serious. Punishments for such behaviour (expression of sexual desires or cross gender proscribed relationships) in Pakistan, particularly for women could be severe, including death (Khan, 2003). Henry (1977) suggests that people remember successful cases of remission for a long time but forget the failures or blame themselves for breaking the rules. The cases of illness that did persist were attributed to fate, or God's will. In the current research, cases of failure were not broadcast quite unlike cases of success. There was complete denial amongst attendees that anyone was a lost cause.

Whilst this perceived level of responsibility and apparent control was clearly extremely positive for many of the participants it was not necessarily an approach that suited everyone. It may have put off others from coming to the Shrine in the first place. Those attendees who voluntarily stayed for long periods at the Shrine clearly felt its benefits and felt comfortable with the degree of control and responsibility that was afforded to them by the Shrine experience. Those who left early or thought about discontinuing their 'treatment' may have done so because they could not cope with the level of responsibility for making

decisions for themselves. In those cases ‘missing their children at home’ or ‘financial pressures’ may have provided justifications for leaving early. Interestingly, this also left the door open for them to return if they experienced another and possibly more severe attack from the evil spirits in the future.

There was little evidence of external controls at the Shrine. The only ‘members of staff’ present were the caretakers whose role was usually to maintain some level of order and discipline in the environment. The male caretaker in particular was sceptical of aspects of the process taking place at the Shrine; he interpreted particularly women coming to the Shrine as an attempt to escape their duties at home or as an excuse for inappropriate behaviour and expression of loose moral character. The attendees emphasised the need to keep on the right side of the caretakers in order to ‘have an easier life’. However, the caretakers remained peripheral characters. They contributed marginally to the therapeutic environment in terms of demarcating geographical and behavioural boundaries and maintaining a degree of safety by keeping out unwanted characters. These included self proclaimed healers, and drug dealers, or those who preyed on vulnerable people.

DE-STIGMATISING OR STIGMATISING

In the context of the stigma attached to mental health problems in Pakistan, the Shrine appeared to have a concealing function for many participants and their family members. At the most basic level, the sufferer was ‘hidden’ from most of their immediate family, neighbours, and wider society. The participants who chose self-exile or those who were sent away to a shrine both reflected society’s attitude and lack of tolerance for ‘deviance’ and the difficulty of living in ‘normal society’ while being ‘ill’. Some resolution or remittance of symptoms was called for if normative functioning was to be resumed. Mental health professionals in Pakistan continue to regard those attending shrines with scepticism (Mason, 1987). In my personal experience, shrine attendance is associated with being

naïve, illiterate, superstitious and therefore frowned upon, thus stigmatising this pathway of help seeking, if not the behaviour or problem leading to it.

However, the picture in the Shrine is somewhat different. As discussed earlier, the causative theory of supernatural possession helped in reducing stigma and discrediting from society. The therapy (*hazri*) played a crucial role in reframing a situation that was potentially very stigmatising as one that engendered respect.

Kleinman (1988, p. 159) suggests that “the bizarre actions of florid mental illness stigmatise because they break cultural conventions about what is acceptable appearance and behaviour, while invoking other cultural categories – of what is ugly, feared, alien, or inhuman.” Goffman (1963) suggests that if the source of stigma is visible, it is deeply discrediting. However if it can be concealed from others, the sense of being discredited can be internalised by the person. In either case, the person feels inferior, degraded, deviant, and shamefully different.

In the world or theatre of the Shrine, the sufferers’ “bizarre actions of florid mental illness” (Kleinman, 1988) were reframed as something positive and something to be admired by those witnessing the outward display of distress and the process of therapy or treatment (*hazri*). The “bizarre actions” were seen as an outward manifestation of the fight between ‘good’ (the Saint) and ‘evil’ (the jinn or devil). The more dramatic the behaviour or ‘fight’ the greater the confirmation that the individual sufferer was under the influence of a malign force. The stronger the evil possessing them the more dramatic and violent the ‘fight’, and attempts to expunge the evil jinn or magic from the body. The behaviour once viewed as ‘bizarre’ in another context was then accepted and even revered by the audience at the Shrine. The outward display of the conflict demonstrated to all observers the actual treatment process in action (Pfleiderer, 1985) and gave hope to others of a miracle cure for their own problem. Head-

banging, somersaulting, the breaking of bangles and self-harm became the norm for behaviour expected during an 'open *hazri*' and although may be considered 'inhuman' (Kleinman, 1988), provoked by the behaviour of a non-human (the jinn), it was no longer considered 'discrediting' (Goffman, 1963).

The healing regime at the Shrine often acted to reduce stigma and reframed the behaviour positively in the eyes of the participant and the audience as blame was assigned to the jinn rather than the individual (Pfleiderer, 1985). Western psychiatry on the other hand can be said to further stigmatise an individual and their family and frame the 'problem' negatively as upon admission to a mental institution, the patient is perceived to have suffered a 'breakdown' as a result of a personal failure of some sort. S/he suffers a massive loss of status and becomes less than a fully fledged member of society (Goffman, 1961). The psychiatric hospital may conceal the person and their problem from their community; however, it does not go so far as to transform the problem into a positive. Recovery from mental illness is sometimes applauded and seen positively by a wider audience but the problem (mental illness) itself is rarely considered a positive whilst the condition or behaviour persists, which contrasts dramatically with the healing process at the Shrine.

Overall, it appeared from the attendees' narratives that once the problem of possession was validated (by a faith healer or at the Shrine by the Saint), it generated a difference in attitude towards them. Negative attitudes changed into awe or fear and they were treated with more respect and caution than before.

LIVING IN A LIMINAL SPACE OR BEING INSTITUTIONALISED

Sense of place defines the identity, significance, meaning, intention, and felt value that are given to places by individuals (Pred, 1976; Tuan, 1976, cited in Williams, 1998). For the majority of attendees the Shrine provided a safe space, a retreat, and respite where anybody could go. The attendees were free to stay as long as they wished. It often provided a sanctuary from a stressful home

environment and allowed time for rest and recuperation. The Shrine symbolically brings those living there to a liminal state (Turner & Turner, 1978), not among the living (in external society) and not among the dead (whose presence is symbolised by the gravestones in the surrounding cemetery). Being in this space can also be seen as a reminder of the impermanence of this world and refocus attention on the purpose of attendees' lives and Islamic beliefs and rituals (Ashraf, 1987 ; Hassan, 2002). As Gesler (1992) summarises "place provides meaning for people in many different ways; through identity and feelings of security, as settings for family life and employment, as locales for aesthetic experiences" (p. 738). The Shrine as a liminal space allowed an attendee's identity to be transformed to some extent, bringing about 'disorientation', a situation that led to new perspectives on their lives (Turner & Turner, 1978).

It is through the lived experience in a particular place that "moral, value, and aesthetic judgements are transferred to particular sites which, as a result, acquire a spirit or personality" (Jackson, 1989). People are then able to connote a place with a sense of positive or negative energy based on their experience and the meaning they found at the place. Considering the socio-cultural background of the attendees, the experience of being on their own (at the Shrine), allowed them to focus on themselves, and examine their fears, needs, and priorities. The resulting feelings may have varied. However, for the majority of participants interviewed, the Shrine was therapeutic and promoted a sense of healing.

For some attendees, it also seemed to provide a way of achieving changes, in self or their families that would help them re-integrate into society. Some attendees visited the Shrine and returned home repeatedly and each time they visited some small change occurred. The Shrine appeared to help remould or remodel. In this way, time spent at the Shrine could be considered a 'rite of passage', (Turner & Turner, 1978) where those, suspended from society, came back and forth until they found a 'fit' that eventually allowed them to return home having

renegotiated a permanent re-integration which most attendees hoped to achieve one day.

Being away from normative society in an isolated and contained space, sometimes for several years also raised issues in relation to the institutionalising nature of the Shrine. Institutionalisation refers to the process of becoming accustomed to life in an institution so that it is difficult to resume normal life after leaving (Goffman, 1961). Some attendees' had lived at the Shrine for many years and gave little sign that they were likely to leave, thus suggesting that they had become institutionalised. While some lived at the Shrine for a long time, others moved from one shrine to another after failing to settle back into their home lives, seeming to prefer the life or institution of the Shrine (or perhaps a preference for being in a liminal space). There was contact from time to time with the outside world, particularly for those who worked locally or when relatives visited. However, there was exclusion from normal societal living and the adaptations attendees made to the life and rhythm of the Shrine resonated with the concept of institutionalisation found in mental institutions (Goffman, 1961). Some attendees, who had been discredited in and by society, gave up on society and lived in the Shrine where they found a degree of acceptance and a sense of well-being in the environment and its expectations.

For those rejected by society, it seemed as though the Shrine had become a sanctuary and for those who had been failed by other sources of treatment or help, it became a centre for healing. It was largely for these reasons that attendees remained at the Shrine or visited repeatedly, rather than a set of institutionalised rules leading to institutionalised behaviour (Goffman, 1961). The Shrine differed from a typical 'institution' in the way that it allowed attendees to create their own space and treatment as they would like it to be. Psychiatric institutions, on the other hand, particularly from my experience in Pakistan, often inhibit creativity, demand conformity, and the rigid following of rules and timetables. The Shrine, although it provided a loose structure and

daily activity regime to follow; did not demand rigid conformity to a large number of rules. There was little enforcement of rules as such. There was choice and negotiation around treatment length, through internal dialogue with the Saint for example. Institutions tend to take away individual choice whilst the Shrine allowed a degree of choice. Choice, negotiation, creativity, involvement, and the 'design' of own treatment package are not concepts usually found in an institution. These factors may have been crucial in self healing.

RESILIENCE OR VULNERABILITY (GOOD OR EVIL)

Through the almost physical interaction between the attendee and the dead Saint, the fight between the 'good self' and 'the evil' that was in possession of their body was evident. The 'evil self' or 'ill self' was identified by others as the perpetrator of undesirable behaviour and the cause of symptoms and problems. The 'good self' or 'well self' was seen to put up a fight against the 'evil self' supported in its efforts by the Saint. When the 'well-self' and the 'ill-self' became separated, the 'illness' was externalised and fought or battled against until eventually overcome. This was almost a literal fighting of demons, performed as part of *hazri* in front of the audience. This may have made it easier to reintegrate the divided selves, once the positive or 'well self' was seen to overcome the negative or 'ill self'.

This process led to reinforcement of socio-culturally constructed ways of enduring and coping and promoted a sense of 'strength'. This strength allowed the sufferer to cope through the utilisation of their own resources and networks and to develop positive strategies to deal with disequilibrium and disharmony both within the self and in relation to others, while being and feeling supported by the Saint. Contrary to this, psychiatry has had a tendency to label any sign of distress as 'unnecessary' or 'pathological' and promotes the idea that allopathic interventions can solve any problem (Summerfield, 2006). Illich (1975) notes that human suffering that was once accepted as the 'will of God' has, with the secularisation of the Western society, become a 'problem' - an undesirable

condition for scientists to solve. The ‘ill self’ in the mental health system in my experience overtakes the ‘well self’ thus changing the identity of an individual so that they are seen as vulnerable and ill rather than capable and resilient (Summerfield, 2004).

The healer’s ability to explain what is wrong with the person and to name the problem can be instrumental in reducing a person’s anxiety or vulnerability (Henry, 1977). Psychiatric diagnoses of anxiety, depression or schizophrenia may further a person’s confusion in a society (like Pakistan) where mental health literacy is already very low (Suhail, 2007) and anything diagnosed as mental illness is labelled as ‘*paagal*’ (crazy). Diagnoses of mental disorder in the western world, where mental health literacy is higher, are still frequently questioned and this is likely to be due to the complex nature of diagnosis and its underpinning in the social world. Whether it was the experience of being there ‘in a liminal space’ that enabled the person to change perspectives on their situation, gain understanding of their problem, and reconnect with their own strengths, or it was the influence of peers’ perspectives of the problem, that changed an attendee’s perception of her/his problem and increased their resilience is not clear. Regardless of their vulnerability, many attendees came from very abusive home situations, the focus on the possibility of and hope for a miracle cure, and the perceived ability to influence the outcome through prayer and connection to the Saint reinforced their coping and resilience.

The Shrine as a place of healing offered up a number of sometimes contradictory and ambiguous experiences to attendees. There were opportunities for positive and therapeutic experiences and perspectives which were embraced by many attendees. At the same time the risk of harm and non-therapeutic experiences was more than possible. Many attendees employed strategies to mitigate the risks and chose to focus on the positive aspects of their stay. The Shrine community, although involved in conflict at times, was overall supportive to its members and helped reframe the problem in a positive light.

Many attendees appeared to be in control of the treatment process and increasingly empowered within the family system, although this was not openly acknowledged. For a small minority however, the Shrine remained a prison they could not escape from.

THE SHRINE AND BIOMEDICAL HEALTH CARE SYSTEM IN PARALLEL

According to Meade, Florin & Gesler (1988) health care delivery systems consist of ill people and practitioners who diagnose and treat illness. A good medical system also tries to enhance health, prevent ill health, and assist in creating a healthy care environment. There needs to be a good relationship between healer and patient existing within a wider context of social institution. The system also embraces beliefs involving health education, dietary taboos, State policies concerning the distribution of health resources, the social and financial status of people and their causative theories about ill health or disease.

In the previous section, I have discussed how the rituals taking place were considered important in the healing experiences for a majority of the attendees. Their perceived rapport with the healer and reputation of the Shrine for healing, the therapeutic milieu within the Shrine, and positive reframing of the problem were all important aspects of the healing process. Along with these, the destigmatising effect of being at the Shrine and an environment conducive to reflection without day-to-day stressors made the Shrine therapeutic for many attendees.

I will now examine the Shrine as a centre of alternative healing. The Shrine, although not formally considered by the government as a health resource, was utilised as such by many. It ran parallel to or sometimes followed on from or overlapped with a biomedical approach to the treatment of the problem experienced by the attendees. The following section describes some of the main

aspects of the two systems. Table 1 (Appendix 7) briefly summarises the similarities, differences and overlap between allopathic care and the Shrine as an alternative health care system.

THE PLACE AND THE HEALER/THERAPIST

The healer's personality, their reputation, their understanding of the context, competency in understanding the illness, the setting in which healing takes place, the curing rituals and the offering of an acceptable and affordable solution, all contribute towards meeting expectations of healing (Henry, 1977 ; Chadda et al., 2001 ; Halliburton, 2004). Henry (1977) also highlights the importance of the apparent effects of the rituals performed, the history of the place and its relationship with the nature of healing, and the situation of the attendees in regard to need, in contributing to the healing experience.

Biomedical treatment approaches to mental health problems are offered in general hospitals and clinics in towns and cities in Pakistan. It is expected that individuals or families will recognise the need for help and make the necessary arrangements (financial, transport, human) in order to see a doctor. Shrines on the other hand, are scattered all over the country, some are close to cities whilst others are located in rural and deserted places. Some shrines are open only during the day while others allow visitors to stay overnight or for longer periods.

A crucial factor in promoting healing relates to healers themselves. Medical health care is delivered by doctors mainly using pharmaceutical interventions. Physicians practising privately in the community are the main source of medical help for ordinary citizens in Pakistan. However, they are often ill-equipped with the knowledge or skills to deal with issues of a psychological nature (Thaver et al., 1998 ; Deva, 2002 ; Khan, 2006). Attendees had had largely unsatisfactory experiences with medical practitioners. They felt misunderstood, their concern not taken seriously and the problem and treatment was not explained in a way that fit their world view.

At the Shrine, the spirit of the dead Sufi Saint was given the power to heal based on a 'spiritual contract' which an attendee made with (the spirit of) the Saint. The contract, the interaction, the mode of treatment, all are mystical and cannot be challenged or fully comprehended by an outsider. The failure of treatment was hardly ever blamed on the Saint. There was a belief that the spirit of the Saint was very close to Allah (Werbner, 2003) and that by placing blame on him for treatment failure a person may only be inviting more misfortune for themselves and their families. This was contrary to their experiences with medical help where doctors were blamed for the failure to recover, although not challenged directly.

Apparent absence of healer

What makes the Shrine and the healing phenomenon taking place particularly fascinating is the apparent absence of a tangible person or healer acting as a guide or intercessory for attendees in the healing process. In other research that has taken place in shrines, temples or places of worship, the absence of a living guide has not been remarked upon or given any attention (Pfleiderer, 1985 ; Pfleiderer, 1988 ; Hussain et al., 2001 ; Malik and Bokharey, 2001 ; Halliburton, 2003 ; Padmavati et al., 2005). The process at the Shrine is based on a mystical interaction between the attendee and the spirit of the dead Saint, through a self-induced trance. There is no third party involved in the communication between the attendee and the long dead Saint. Werbner (2003) from her observations at the lodge of Saint Zindapir in Pakistan found that a dead saint was perceived to be still alive and "a hundred times more powerful in the grave than during his lifetime" (p. 260). The relationship with the Saint and communication with Him was constructed by the attendee, although this remained unacknowledged. There was no trained or living person who helped or taught the attendees the process of inducing a trance.

HEALER AND PATIENT INTERACTIONS – LOCUS OF CONTROL

In the current study, those who had consulted doctors for their problems had experienced an often hierarchical and patronising approach which failed to involve them or provide an adequate explanation of what was wrong with them, or the treatment process on offer. The image of doctors as expert healers, led attendees to hand over power to them and they failed to question or challenge what they did not understand. If treatment was unacceptable or failed to bring about improvement they simply moved on to another doctor or took a different path to healing. The medical treatment process often stretched over months with no apparent visible change in the problem and this raised questions about the competency of physicians or appropriateness of the treatment.

Chadda et al (2001) found that lack of awareness of psychiatric specialists among people contributed to their unsatisfactory experiences with medical help. Combined with this, the lack of experience and little or no continuing professional development among private practitioners (Thaver et al., 1998) and the influence of pharmaceutical companies (Khan, 2006) often left patients with inaccurate diagnoses or resulted in the over-prescription of psychotropic drugs often resulting in unpleasant side effects and a drain on families' financial resources.

Compared to this, the healing regime at the Shrine made 'sense' to the participants in the current study. The prevalent discourse at the Shrine, constantly reiterated and reinforced by both long-term resident attendees and short-term visitors, described how the Saint miraculously intervened to destroy the evil possessing them and counteracted the magic. This discourse of miracles encouraged the attendee to establish trust in the Saint and the process and instilled hope.

This offer of hope seemed very important in engaging and keeping attendees at the Shrine. Traditional healing appears to succeed where biomedicine fails by

recognising the links between the problem and social, moral, and religious events. The provision of secure grounding through traditional beliefs and healing systems can also be the reason for the success of traditional healing system especially for people undergoing major changes in their lives (Dein and Sembhi, 2001).

With the subtle shift of power to the attendee from other family members, discussed earlier in the chapter, it seemed as though the attendees were effectively healing themselves and attributing that healing to the spiritual entity, the Saint. It may have been more acceptable to attribute the healing power to another, an invisible and unknowable source than to say 'I am powerful and I can take care of myself'. By putting themselves in an apparently helpless state in front of the grave of a male Saint and labelling it religious or spiritual healing conferred religious legitimacy and conformed to cultural expectations. This made it more acceptable in a classically patriarchal society.

Leading on from this it appears to be less threatening, in a patriarchal society to accept the possibility of a miracle than the likelihood of women's power or women's empowerment. In many places of religious healing the guide or *murad* is most likely to be a male. If there were living male healers at the Shrine it might make it even more difficult for women to participate in the therapeutic process.

CAUSATIVE EXPLANATIONS AND LABELING THE PROBLEM

Regardless of how the symptoms were perceived by the actors, their families and their community, they caused disharmony in the family and among their wider social network. Pakistan can be considered a vertical collectivist society (Triandis, 2001). It is a society that places a great emphasis on kinship, community, and togetherness. Human interdependence and collectiveness is considered far more important than the wants and desires of separate individuals. The focus in collectivist societies is on community and society and

priority is given to group goals (Leung and Stephan, 2001 ; Summerfield, 2004). In close knit societies, as in Pakistan, reputation, family respect and prestige is based on family members' social persona in the community, therefore being 'different' invites suspicion and unease. For participants, bizarre behaviour or other forms of deviance from the cultural norms resulted in the person standing out and gaining a negative reputation (Mirza et al, 2006). It is not only bizarre behaviour that invites attention and threaten the family name, but also how the women of the family conduct themselves in the public sphere, abiding by social rules and being a vessel for family honour (Moghadam, 1992).

The symptoms experienced by the participants when perceived as 'possessed' or 'under a magic spell' affected their ability to perform their role at home or outside thus in turn affecting family dynamics, relationships, and economic stability. Women's ability to sustain their familial role and domestic duties are essential to the maintenance of harmony in the household and often the prime reason for seeking help (Winkvist and Akhtar, 2000). Similarly, men's ability to earn, to protect, and to maintain their family was essential. The resulting disharmony in family relationships, social distancing from the community, along with perceived diminished future prospects for other family members were often the catalyst for seeking help. Goffman (1961) suggests that it is often not the illness behaviour that leads to help seeking but help is sought when another problem arises within the family which affects their ability to carry on supporting the ill person. For attendees, the escalation of the problem or additional family life events compounding the problem (social ostracism, job loss, or family conflicts) and the resulting disequilibrium was instrumental in steering the family towards actively seeking a solution.

If seen through the lens of western psychiatry, the symptoms described by the attendees could be labelled as Generalised anxiety disorder, Panic disorders with or without phobias, Dissociative disorders, Depression (moderate to severe), learning disabilities (secondary to Epileptic disorder and Cerebral

Palsy), Dementia, Paranoid psychosis, Manic depressive psychosis, and Schizophrenia using ICD 10 (International Statistical Classification of Diseases and Related Health Problems) or DSM IV (Diagnostic and Statistical Manual of Mental Disorders). Western psychiatry would not interpret beliefs about possession as a cause of a problem but as another symptom, and may categorise it as a delusional belief when measured against mainstream western thought and belief (F44.3 Trance and possession disorders F44.7 Mixed dissociative (conversion) disorders).

However, none of the participants viewed the problems in the light of mental illness and these labels would have meant nothing to them. Even those who originally considered their problem to be medical in origin changed their minds following the failure to improve after medical treatment. The symptoms and diagnoses were not uncommon when compared with those attending other shrines and faith healers in the Indian Subcontinent as reported in several studies (Satija and Nathawat, 1984 ; Saeed et al., 2000 ; Halliburton, 2005 ; Padmavati et al., 2005).

Help was initially sought by many attendees from allopathic/biomedical healers and/or faith healers and efforts were made to eliminate the sickness. Often as the problem persisted, different healers were tried. As it became more chronic it began to involve the whole family system rather than locating itself solely within the individual. It was often at this point that many participants received a '*bishaarat*' (message from the Saint). With no adequate understanding of what this illness was, the participants decided to come to the Shrine initially to see if it would help. For some families it also meant a decision being taken by them to bring their acutely ill relatives or family members – against their wishes. This clearly relates to what Williams & Healey (2001) characterise as 'movement and uncertainty' as meaning is sought and established and the explanatory model takes shape.

Research which has looked at psychiatric illness and its appraisal by people in Pakistan (see literature review), reveals people's perceptions of these problems to be related to magico-religious, supernatural and hereditary causes. A lack of comprehension of the treatment process combined with beliefs which contradicted the medical basis of the 'problem' resulted in mistrust of the healing offered by medical practitioners.

In Pakistan, while health information concerning western medicine is accessible only to those who are educated and have access to printed or electronic media, others (those illiterate or disadvantaged) rely totally on an oral tradition for health education and the dissemination of information. Mental illnesses are not portrayed favourably in the media and this further reinforces peoples' supernatural theories (Bhugra, 2005). It is remarkable how stories of jinn and witchcraft are passed from one generation to the next. These stories are common in the media and on every street there is a self proclaimed healer claiming to exorcise jinn. These traditions based on values and understandings are held in a virtual space, supported by a little printed material elaborating theories pertaining to the supernatural world.

CONSENT

The majority of the attendees at the Shrine visited because they chose to. However, there was a small minority who were tied and kept at the Shrine against their will. In those cases, parents or elders of the family had made the decision to seek help at the Shrine. The situation is very similar in mental health hospitals, where patients are admitted at the request of the family and is dependent upon their ability to pay for the treatment. Although Pakistan's Mental Health Act of 2003 has been approved, it has not in reality been implemented especially in the private sector which is the major provider of mental health care (Gilani et al., 2005). In addition, it is common practice in hospitals to apply restraints to patients who are acutely disturbed.

TREATMENT OR THERAPY ORIENTATION

Biomedicine is understood to follow natural laws which have nothing to do with the supernatural, or their social context and gives precedence to technique over a person and their social identity within a community (Kleinman and Good, 1985). The variety of problems that often presented at the Shrine, when assessed by a medical practitioner, had been treated with antipsychotics, antidepressants, tranquilisers, and mood stabilisers with the aim of controlling problematic symptoms (Gadit and Khalid, 2002 ; Gadit, 2003 ; Khan, 2006). Some of the participants also experienced treatments such as ECT (often administered without anaesthesia in Pakistan). The medications as well as ECT, were often perceived to be detrimental as they caused unpleasant side-effects and further complications in attendees' physical health (Rana and Ayub, 2002).

Not many of the participants were offered or could afford in-patient treatment at private psychiatric facilities and had taken prescribed medication while continuing to live at home in the same stressful environment. Those who were admitted found themselves in very basic and often unsafe environments, where they spent most of their time in bed, took medications, and waited for the problem to go away. Others made repeated visits to local doctors and hospitals for months or years, hoping that the medications would alleviate the problem. Medical/psychiatric treatment did not include any family work; psychological mindedness has yet to be widely established in Pakistan.

As discussed earlier, at the Shrine a structured set of interventions were not provided. In the apparent absence of a healer, the participants found spiritual interaction with the Saint, adoption of modest ways of living, engagement in prayer and religious rituals, and interacting with other attendees to be what benefited them. There seemed to be the formation of a self-help group in which people supported each other and in some ways held their distress until things improved.

Being away from home also removed the trigger factors that may have initially contributed in the development of the problem. Being in the place which was perceived to be 'conducive to healing' (Gesler, 1996) also revived their sense of hope of getting better and resuming a 'normal life', this was further validated by the discourses of miracle which were shared and narrated.

Bishaarat and *hazri*, the interaction between the Saint and the attendee, although focused on the individual, also had significant impact on the family. As a result of changing dynamics, and the previously described power shift towards the individual, attendees achieved more control over their lives.

The situation was different for those who were kept at the Shrine against their will. Although their narratives could not be obtained during this research, they were observed to be screaming and weeping throughout the day. They were also watched by others as entertainment possibly causing further humiliation.

Mirza et al (2006) reports that those attending psychiatric hospitals or clinics in Pakistan predominantly located the basis of their problem in their social world. Western psychiatry largely views mental symptoms as pathological and in need of pharmacological intervention. It focuses on treatment of the individual and the development of the individual. It is interesting to consider how well this framework or understanding of problems 'fits' in a collectivist society where the individual is important only as a member of the group (Triandis, 2001). Secondly, how can a medical approach treat the causes of 'oppression'? In fact, conversely the medicating of women could be interpreted as helping them to conform to societal norms which may be oppressive in nature (Humphreys and Thiara, 2003). In addition, if the 'problem' is the consequence of domestic violence and abuse (as is very common in Pakistan), how can a medical approach deal with this by focusing on symptoms in isolation and disconnected from the abuse (Niaz, 2004).

While psychiatric treatment in Pakistan embraces treatment frameworks from Western concepts of health and disease and University education loosely governed by the medical regulating body PMDC (Pakistan Medical and Dental College), the approach at the Shrine is eclectic. There exists a combination of Islamic teaching, sermons by the Imam of the mosque, teaching from frequently visiting religious leaders and stories about the supernatural which are passed on from generation to generation.

STIGMA

As discussed earlier, being mentally ill and receiving treatment in hospital and being possessed and receiving treatment at the Shrine both caused stigma for the individual and the family. The stigma attached to being mentally ill is far greater than that attached to being possessed as mental illness is popularly considered to be a permanent condition whereas possession is considered treatable and therefore temporary.

FINANCIAL REQUIREMENTS

As stated earlier, the financial consequences of seeking treatment, either at allopathic centres or at the Shrine were often draining for the attendees and their families. While allopathic treatment required money in terms of doctors' fees, purchasing medications, diagnostic tests and travel, healing at the Shrine required finances for full board and travel. In countries like Pakistan, it is more acceptable to seek medical help and bear the financial consequences for conditions which are acute or short term. However, for chronic conditions (such as mental health problems), other sources of help are often explored that can be more affordable in the long-term (James et al., 2002 ; Gadit, 2004).

Despite advances in medical psychiatry, a majority of patients using psychiatric medications still suffer from high cost implications and debilitating side effects – both in the short and long term (Rana and Ayub, 2002 ; Gadit, 2004 ; Taj and

Khan, 2005). High financial costs and the inability of people to afford psychotropic medications for an unlimited time period led participants in the current study to look for more affordable sources of help.

Being a collectivist society, people depend on family resources rather than individual wealth (Moghadam, 1992). Unfortunately as women do not have any economic power, they have to depend upon males to appraise the problem as serious enough to seek help (Winkvist and Akhtar, 2000 ; Fikree and Pasha, 2004). Long term residence at the Shrine affected the whole family. The degree to which they were affected depended upon the gender of the attendee, their employment status, and the overall financial state of the family. As the majority of the Shrine attendees were women, the effect on families was mainly functional, whereas for those families whose male members resided at the Shrine, their children and sometimes extended family members contributed and compensated for the deficit in income at home. At the Shrine, financial hardships were less than at home as people modified their lifestyle and depended on donations and food distributions. As most of them did not take any medication, the immediate financial stress of medical costs was lifted from the family.

AFTERCARE

In both the systems, the responsibility for aftercare lies with the individual and their family members. For those seeking psychiatric treatment, follow up visits need to be arranged and paid for. For those seeking healing at the Shrine, often a monthly visit on the day of *nochandi* was suggested. Attendees and their family members were also expected to offer food to the poor, continue praying and modifying their lifestyles and integrate Islamic rituals into their lives once they are at home.

When compared to existing allopathic health care facilities in Pakistan, the Shrine proved to be an attractive source of help for most attendees. Undoubted

deficiencies in the government psychiatric system, lack of explanation of diagnoses and treatment by practitioners, unpleasant treatments and side effects and lack of the necessary finances meant that attendees often left medical treatment early, if they tried it at all. In contrast the Shrine seemed to offer a treatment based on explanations that made sense to attendees. Control was usually with the attendee rather than with a practitioner as such, and on the whole use, of the Shrine was cheaper.

Supportive relationships with other attendees developed and these played a significant role in meeting the emotional and social needs of attendees. This 'emotional ecology' of the Shrine itself, the healing powers of *lunghar*, the atmosphere of peace, the sense of nurturing that it provided to its attendees and the social support, all seem important contributors to the healing process (Werbner, 2003). The level of stigma experienced by attendees at the Shrine was also somewhat lower than for those labelled 'crazy' or 'mentally ill'. It was interesting that the 'healer' existed only in the spiritual world and was therefore 'absent'.

THE SHRINE AS A THERAPEUTIC LANDSCAPE

The Shrine seemed to be universally considered a healing environment by attendees. Social conditions, human perceptions and belief systems, and the geographical location and symbolic significance of the Shrine combined to make it a therapeutic landscape, 'a place conducive to healing' (Gesler, 1996 p.96). All places have the capacity to be therapeutic landscapes based on the context and circumstances creating a therapeutic 'sense of place' (Relph, 1976 p. 43). The Shrine for participants in the current study, was much more than a simple location with physical characteristics and provided context dependent healing for attendees in a similar way to subjects in other studies who preferred treatment in a variety of settings such as home, hospital, or hospice (Williams, 1998 ; Milligan et al., 2004 ; Martin et al., 2005 ; Watson et al., 2007 ; English et al., 2008).

I will now turn to consideration of the social conditions and structures in Pakistan and how these in combination with beliefs and perceptions, affected participants' choice of healing pathway and brought them to the Shrine. Following this I will look at the Shrine as a therapeutic landscape.

SOCIAL CONDITIONS AND HUMAN PERCEPTIONS

Adverse and oppressive social conditions and a culture of patriarchy and collectivism set the background and context for a society where individual's transgression of socially ascribed norms was not tolerated. The enacting of behaviours considered deviant led to shame, loss of face and family honour and motivated the family to seek help. For the participants and their families, this help-seeking followed a number of pathways to both a more western oriented biomedical approach to illness and other alternative sources of health care involving faith and religious healers. Poverty and inequality as well as a lack of 'psychiatric expertise' often limited the choices available (Chisholm et al., 2000 ; Gadit and Khalid, 2002 ; James et al., 2002 ; Gadit, 2004 ; Husain et al., 2004 ; Karim et al., 2004 ; Gilani et al., 2005).

Although religion is not necessarily a social condition, in the context of Pakistan, religion is an essential part of the social fabric and provides a framework for the constitution and affairs of State (Pakistan is an Islamic Republic). In this sense it can be said to contribute to social conditions or structures such as limited opportunities and the strict moral regulation of behaviour, particularly applied to women (Khan, 2003 ; Karim et al., 2004).

Perceptions concerning the problem and explanations of its cause focused on the supernatural. There were doubts about the relevance of biomedical approaches when it came to causes and treatment. For some, these doubts were reaffirmed by negative experiences with medication and other treatment (such as ECT) which they found to be ineffective or unpleasant.

Stories of miracles told and retold at the Shrine on a daily basis were highly significant. The discourse of miraculous healing and the powers of the Saint were nurtured and passed on from one visitor to the next. The association between the Shrine and its healing tradition and Islam conveyed religious legitimacy and affirmed the decision to seek healing. For many, the process of healing at the Shrine conveyed not only hope of a miraculous recovery but it was also a religious experience offering salvation in this world and the next.

Social conditions and human perceptions both affect each other. Misinterpretation of religious texts and a culture of patriarchy supported attitudes towards and the practice of keeping women veiled and restricting their access to education and paid work outside the home thus promoting oppression and maintaining a cycle of poverty (Moghadam, 1992). Poverty further affected and placed restrictions on a person's ability to seek and access health care. Limited opportunities for education and work made it more difficult to challenge restrictive practices and left people more open to the acceptance of ideas and beliefs related to supernatural explanations of illness and misfortune. The State education system in Pakistan does not encourage the questioning and challenging of ideas and is based largely on a rote learning approach (Alderman et al., 2001). This in turn makes it less likely that people will challenge notions such as possession or require evidence before adopting the belief. This was evident from the participants, even those who had achieved higher levels of education at college or university. Questioning religious legitimacy is likely to be considered blasphemy and to have serious legal and religious consequences. It could be considered sinful or lead to imprisonment or even death. This acted as a serious disincentive to expressing disbelief or challenging widely held beliefs. Political instability in Pakistan also helped to maintain a lack of development within the country and consequently a lack of access to health care and education.

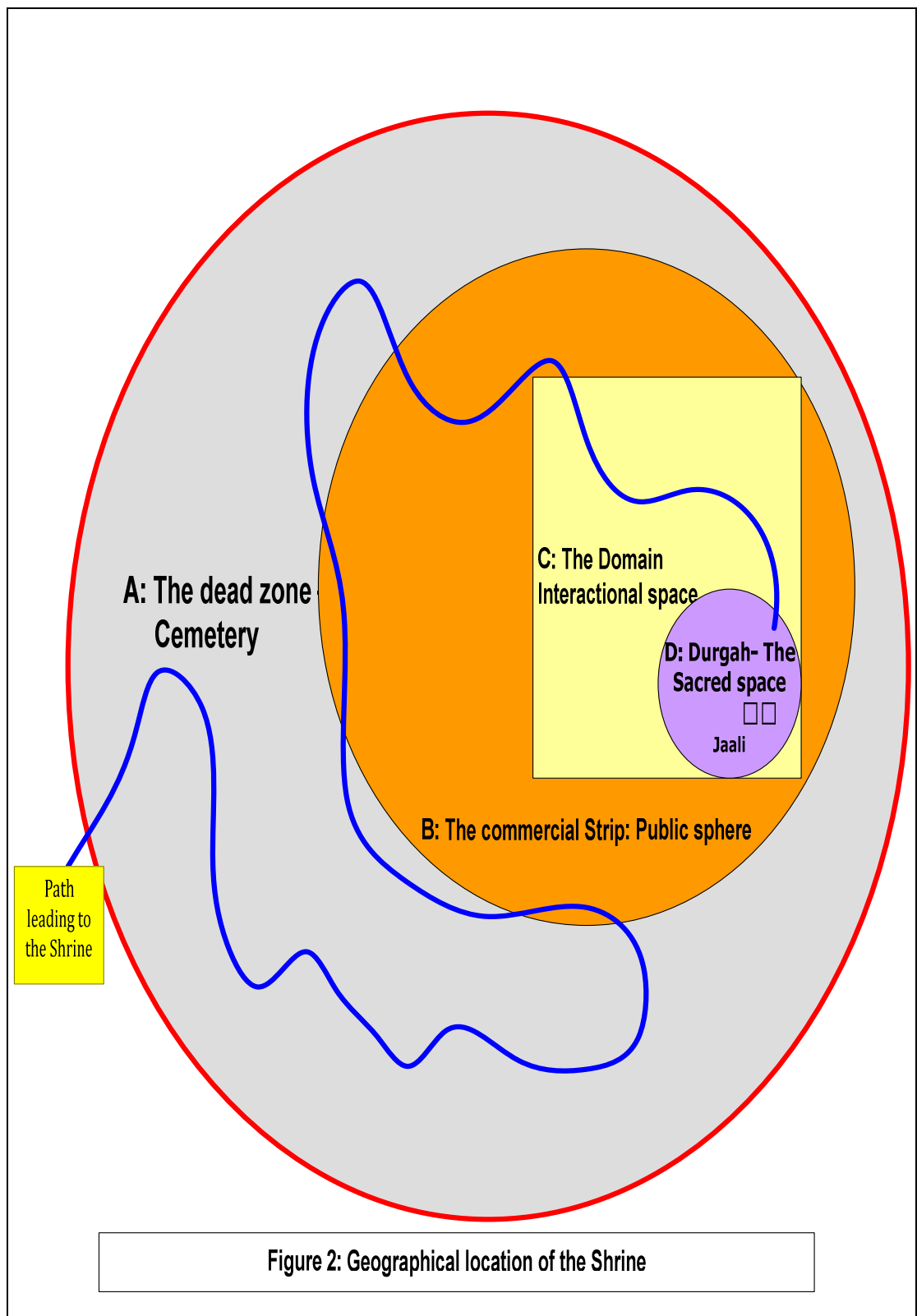
Both social conditions and human perceptions played a very important role in the choice of healing pathway taken by the participants and led them either directly or via other failed, or only partly successful, treatment approaches to the Shrine. Once at the Shrine many of the same factors as well as a reinforcement of their beliefs combined to keep them there.

THE SHRINE – THE PHYSICAL AND BUILT ENVIRONMENT

The social conditions and the perceptions and beliefs of the attendees came together with the environment of the Shrine in such a way as to render the whole landscape therapeutic.

Gesler (1996) noted that many major religious sites are located in ‘peripheral and isolated areas’ and that this may allow pilgrims to cut themselves off from everyday life for a time and contribute to the apparent transforming function that some religious sites possess. He describes Lourdes as an area of spectacular beauty which he suggests is common to many healing places.

In contrast to Lourdes the Shrine in this study is close to Thatta, a small town, surrounded by flat desert that is not considered to be of outstanding physical beauty. The temperature can be exceptionally hot even for Pakistan and there is very little rainfall. The Shrine is relatively isolated and situated on the periphery of Thatta about 2km or a 7 minute rickshaw ride away. It is a very dusty environment with stray dogs roaming outside the Shrine. Similar to Lourdes but on a much smaller scale there are a few shops and hawkers outside. It is a very male environment; there are many flies and much rubbish. It is also very quiet around the Shrine and considered an unsafe space, especially for women. The Shrine compound itself contrasts with the outside space beyond the compound and the graveyard; it is quiet and peaceful; and feels safer and less of a ‘male only’ space.



The journey to the Shrine in this study represents attendees' movement from everyday life to an encounter with the 'divine' (Gesler, 1996) and figure 2 attempts to portray the actual and symbolic nature of the journey. The attendee who wished to go to the Shrine had to travel along a winding track through the cemetery, observing the many graves; and experiencing the desert, an empty space. The place was also perceived as a spiritual space by attendees. Some made reference to sightings of jinn or other supernatural beings in the space as they journeyed to the Shrine, especially if they arrived after dark.

Circle A refers to a 'dead' zone. The several miles of cemetery stretching out around the Shrine represent a sense of abandonment (see picture IV and V in appendix 10). Although some of the tombs are beautiful, they are also weathered and decaying due to age and lack of care. In order to come to the Shrine, each person needs to cross the cemetery on foot or on public transport. High temperatures and a lack of shade make the journey difficult and exhausting, especially for those not feeling physically well. In addition, as it is deserted, it particularly poses a risk to safety for people and their belongings and there have been incidents where people have been robbed of their valuables on the route. Walking along the winding road in the physically and symbolically dead world leads people through a liminal space, where they see graves, tombs, and the markers of death, thus moving from a living space to a dead space and then arriving in an alternative world which reflects an 'in-between' space (Turner and Turner, 1978).

Circle B refers to the thin commercial strip. Hawkers sell cold water, juices, and fruit and vegetables and a few canteen-like places offer hot meals, mainly catering to men as there is no protected space (curtained and sheltered) for females. There are also small shops that sell flowers, scented oils, incense sticks and other items that can be used as offerings at the *durgah* (see pictures VI and VII in appendix 10). These businesses represent the external world, playing loud songs on cassette players; vendors pass sexual comments and remarks and at

times physically and emotionally abuse young children. In many ways, those working in this space connect the outside world with the world of the Shrine. They both bring stories and news from the outside world to the Shrine and take stories from there to the outside world.

Circle C refers to the main domain where interaction with other attendees /sufferers takes place. It can also be perceived as the heart of the therapeutic milieu. This is the space where ‘discourses of miracles’ are communicated and shared. It is a space for the sharing of suffering and where reframing of problems take place. Improvement in people’s lives is witnessed and appreciated and belief in the healing is reinforced. This space is also significant in shaping explanations of the presenting problem. During their stay, the explanatory model of attendees was reshaped and altered.

The innermost part, circle D, refers to the most sacred space that is the *durgah*. It is the place where the grave of the Saint is located. The place is decorated with symbolic colours, ornaments, and flower petals. Paying respects to the *durgah* is an essential ritual for those visiting the Shrine. The *durgah* is a sacred and symbolic space which is perceived to be full of healing power. It represents a liminal and ambiguous place, containing spiritual power assisting those who possess strong beliefs in its authority. It is a male-only space, women are not allowed in the *durgah*.

Ambiguities

As discussed earlier in the chapter, the Shrine represents a world of contradiction and ambiguity. Figure 1 further highlights these.

The journey of an attendee from the city to the Shrine involves not only a physical journey but also a symbolic moving from a living to a liminal space, reminding the traveller of the significance of leaving behind worldly matters and priorities before entering into the sacred and liminal space. Witnessing death

while passing through the dead zone, facing the most ‘feared’, or ‘mysterious’ reality of the world may have changed the way the attendees viewed or feared death. It is also a time for acknowledgement that a person has to ‘face’ the world of the dead in order to be healed and be reinstated into the world of the living.

Harassment and humiliation of the attendees sometimes took place within and just outside the boundaries of the sacred space. Although among the attendees, there was an attitude of sympathy and a sense of shared suffering, the general public including shopkeepers and casual visitors often passed comments, used abusive language, and shouted at them on occasions. I personally experienced piercing stares and sexual innuendo from the male visitors (perceiving me to be an attendee at the Shrine).

The ‘main domain’ or interactional space represented healing and a supportive community for the majority of attendees; it was however also a place where the vulnerable could be at risk. The main domain was where the attendees spent most of their time during their stay. Attendees casually mentioned that they and their children could sometimes be targeted by predators and taken advantage of. Also, with so many people living together in close proximity, this sometimes led to arguments, conflicts, and disputes. Those brought to the Shrine against their wishes and sometimes tied with chains, experienced public humiliation, possibly adding to their distress (see picture VIII in Appendix 10).

The sacred space, most crucial in healing, was accessible only to men. Women of any age were not allowed. There are several explanations given for this exclusion, most commonly concerning women being ‘dirty’ and ‘impure’ due to menstrual blood and discharge (Pfleiderer, 1988 ; Douglas, 2002). The only way they can have sight of the actual grave is through a big window in the *durgah*. This window is covered with a metal grill (*jaali*) and opens into the women’s residence hall. Women considered this *jaali* to be sacred and held it during their ‘communication’ with the Saint. It provided them with visual access to the

durgah. The exclusion of women from the most sacred part of the Shrine is reminiscent of their exclusion from many areas and spaces in everyday life and the social rules that control their access to traditionally ‘male’ spaces, both physical and symbolic. This physical structure in the *durgah* keeps women on the periphery, ‘on the margin’ and restricted, recreating the patriarchal and oppressive culture from which they come. Women appeared to accept these restrictions without much questioning and complied with the rules determined by the Shrine authority just as they largely accepted societal restrictions. The restrictions, limitations, and their status as women were internalised. No challenges were made to the status quo.

In summary, the particular geographical location of the Shrine and the journey to it, both a physical and spiritual journey combined to create a powerful physical landscape. The arriving attendee travelled through the ‘dead’ zone of graves and the commercial strip into the main domain. The inner ‘sanctum’ of the Shrine of the Saint remained out of reach of female attendees. Again the ambiguities and contradictions of the Shrine were apparent. Harassment and humiliation, risks to personal safety and exclusion from the sacred space posed similar restrictions on women to those they experienced in everyday life. Despite this, the Shrine appeared to be a therapeutic landscape.

I will now explore the notion of ‘authentic’ and ‘unauthentic’ landscape and how this applied to the Shrine in the current study. I will then discuss in more depth the therapeutic encounter as experienced by attendees.

THE SHRINE AS AN AUTHENTIC THERAPEUTIC LANDSCAPE

Relph (1976) introduces the concepts of ‘authentic’ and ‘unauthentic’ environments in relation to healing landscapes. This classification distinguishes between “networks of interpersonal concern” found in caring (authentic) environments and “spatial separateness and isolation” found in uncaring (unauthentic) environments (Gesler, 1992 p. 738). Wakefield & McMullan

(2005) have argued that it is possible for places to both hurt and heal at the same time and that the therapeutic effect of place is largely contingent upon the individual's physical and social location. Places are open to multiple meanings (Williams, 1998), which suggests that they will not be 'therapeutic' for all those who visit or stay in the place. The person brings with them their own perceptions, drivers and understandings.

It is clear that the Shrine works as both an 'authentic' as well as 'unauthentic' landscape in the lives of attendees. While the majority of attendees were there voluntarily, there were several who were brought against their will. Most voluntary attendees found the Shrine to be a peaceful, caring, and healing place despite the actual and potential risk of harm. Those forced to attend however, experienced humiliation, physical discomfort, and loss of freedom and autonomy. The ambiguities that existed within the Shrine demonstrated the positive and negative aspects, the hope of a miraculous cure measured against the risk of abuse and harm or the benefits of community or 'communitas' balanced against being away from home. For the majority of participants the Shrine was an 'authentic' therapeutic landscape (see figure 1 for contradiction and ambiguities). For those with a different frame of reference and affected by different social conditions it is likely that the Shrine would have been an 'unauthentic' landscape. In these circumstances the individual would be unlikely to spend time at the Shrine unless as a passing visitor or forced to do so.

Hospitals and health settings are generally considered authentic settings as they aim to offer healing and cure to the suffering, however, in the context of Pakistan (and the situation may be similar in other countries), the lack of interpersonal relationships and partnership in treatment, the stark differences in understanding of causation between patient and healer and unpleasant treatment approaches may make hospitals an 'unauthentic' place for the one seeking healing. Williams (1998) suggests that hospitals are perceived as

negative, hostile, and ‘unauthentic’ because they reduce an individual’s locus of control. Crucially the Shrine appeared to offer substantial control to most attendees over the length and type of treatment. As already described the attendee maintained control over the information they disclosed to others, most importantly other family members, about their interactions with and communications from the Saint. Many attendees, particularly women, found the Shrine to be a liberating and empowering place.

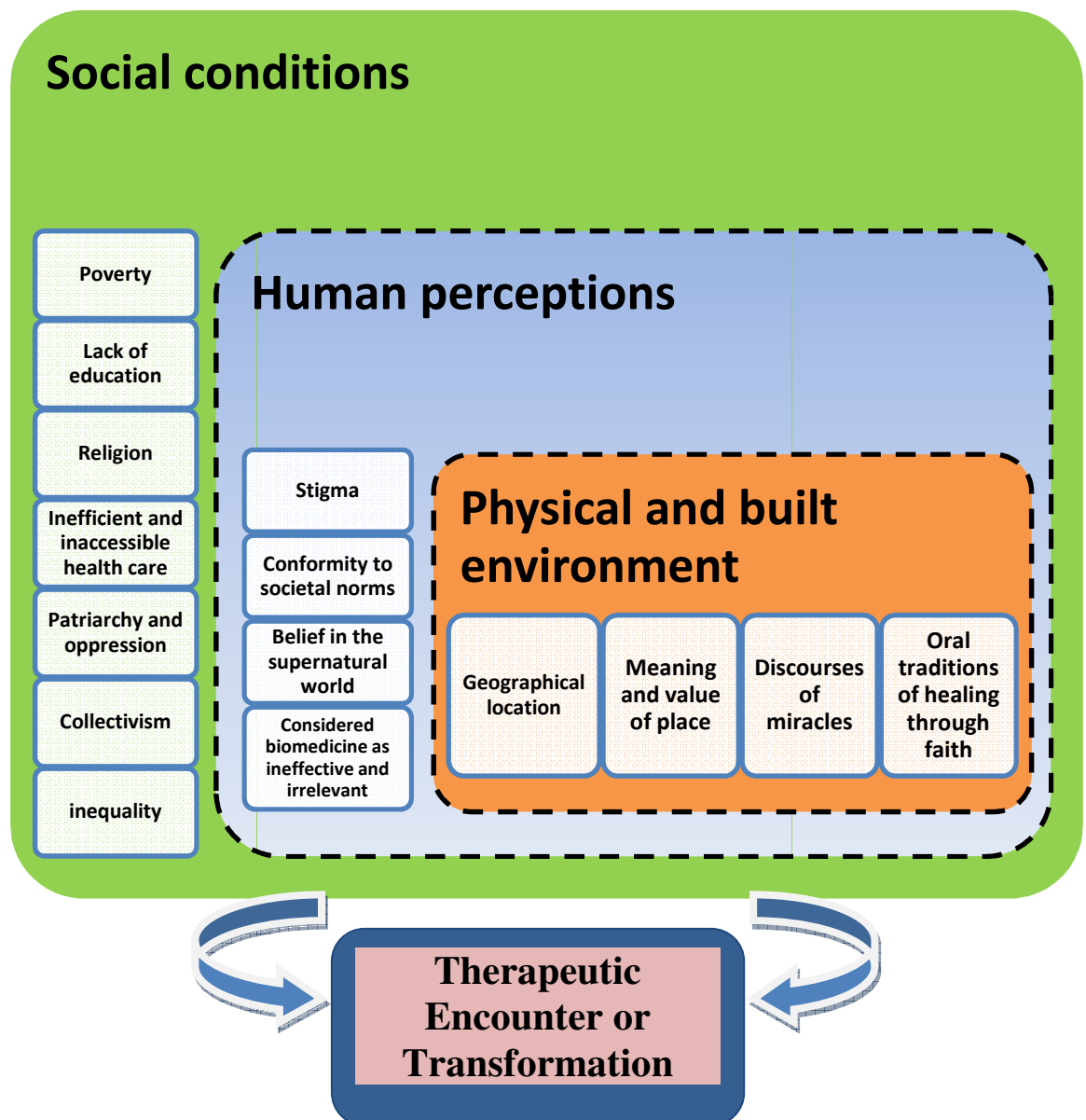


Figure 3: The Shrine as a therapeutic landscape and vessel for therapeutic encounter

Figure 3 summarises how social conditions, human perceptions and the physical and built environment, all come together to make the Shrine a therapeutic landscape.

THE THERAPEUTIC ENCOUNTER (TE) OR TRANSFORMATION

Conradson (2005) highlighted the importance of extending analysis beyond the qualities of the therapeutic landscape to consider and incorporate the interaction of a person with the landscape. For him, the therapeutic landscape experience is best approached as “something that emerges through a complex set of transactions between a person and their broader socio- environmental setting” (p. 338). There is clearly a need to consider a therapeutic landscape and a therapeutic landscape experience or encounter as two different things. The therapeutic landscape is an environment that is ‘conducive to healing’ (Gesler, 1996), whereas the therapeutic encounter is a healing experience that takes place within the therapeutic landscape. The landscape creates the conditions in which the therapeutic encounter can be effectively played out. It is the encounter that ultimately heals the sufferer rather than the landscape itself. It is perhaps the success or otherwise of the therapeutic encounter which decides whether the landscape is an ‘authentic’ or ‘unauthentic’ one.

The healing experience at shrines is often interpreted by researchers and others as ‘religious healing’. However, it appeared in the current study that religion and faith formed part of the healing context or landscape in which the therapeutic encounter took place rather than being a direct cause of the therapeutic improvements experienced. Although the participants considered faith an essential pre-requisite of healing and awaited miraculous cures, when the social processes are unpicked, it appears to be the movement and changes in where power is located within families and between individuals which is key. Whilst on the surface it appeared that the women, in particular accepted restrictions on their life and their marginalisation in society, at another level a huge shift or transfer of power appeared to take place. This was largely covert and publicly

unacknowledged and families appeared to collude in this process. In addition, the positive reframing of symptoms and problems and the renegotiation of identity assisted in transforming the individual within the therapeutic space and together this explains the therapeutic encounter within the wider landscape.

Although the role of religion in the actual healing process could be considered marginal, without a wider religious legitimacy within society it would not have been tolerated. In fact it would not have 'allowed' the apparent movement and transfer of power within the family to take place. The religious foundations of the 'treatment', based on Sufi traditions, if examined in detail may have challenged current Islamic thought. However, the combination of low levels of literacy and lack of knowledge and understanding of Sufism led to a direct failure to question and religious legitimacy was assumed and assured.

What I witnessed at the Shrine was not necessarily 'religious activity' but a social play where the actor attempted to use the context of the Shrine and its religious legitimacy, and the therapeutic milieu to create innovative solutions to their problems. For many of them, this solution extended to their home life and became instrumental in their identity. Interestingly, Pfleiderer (2006) refers to a similar process at the Shrine of Mira Datar (North India) taking place on a stage where the 'spirits masks slip themselves over the people so that they can act' (p. 125).

Pfleiderer (2006) drawing on the work of Stone and Winkelman (1989) describes a technique of self discovery termed 'voice dialogue'. It is assumed that the human personality consists of a number of components which become useful to the individual at different times. Depending upon the nature of the family in which an individual lives, different 'personality constellations' develop forming a social persona. These personas are modified or altered as crises are encountered. At the shrine of Mira Datar, where she carried out her study, suppressed women who had been culturally forced to repress their voices found alternative ways of expressing themselves whilst keeping their social persona's

intact. They spoke through the voices of the evil spirits possessing them during the process they called '*hajri*' (exactly the same process as *hazri* in the current study), in this way 'the impermissible' no longer had to be suppressed. With the mask of possession in place any form of expressing distress became possible without compromising the existing respectable social persona.

Pfleiderer (2006) suggested that women acting out their possession used this to enlarge their own persona which led to "enormous changes in their self perception" (p.125). She went on to suggest that these "demons are weapons that can silence even the largest family of in-laws - but one should not overstep the mark". She also explains that through the process of "enacting their plays" (through *hajri/hazri*) the women were "healed of the monotony of the constant" (p.126). What is very different, however from the current study is that at the Mira Datar shrine only women experienced '*hajri*' whereas at the Shrine of Hazrat Abdullah Shah Asahabi both men and women entered the state of trance or *hazri* and perhaps transformation occurred for both men and women who lived their lives on the peripheries.

The therapeutic encounter that many attendees appeared to experience took place in an open and public place but it also occurred on a private and hidden level. It was couched as religious healing but religion was more part of the landscape than the main transformative element. The attendees underwent a transformation of identity or what Pfleiderer (2006) terms an enlargement of persona leading to changes in self-perception, whilst at the same time maintaining an air of respectability.

The journey undertaken by the attendees from home to Shrine and vice versa was also transforming in itself for many. I will now consider the visit to and participation in the life of the Shrine as a possible 'rite of passage'.

Rite of passage

Turner and Turner (1978) associate a pilgrimage to a 'rite of passage' through 3 phases: 1) separation from a stable set of relationships, 2) 'Liminality' – an ambiguous state, 3) and the end of the journey – a return to old relationships but under new conditions. Although a pilgrimage to the Shrine can be seen in the light of these three stages, there are fundamental differences, which make it more complex.

Attendees' motivations for coming to the Shrine in the first place were frequently provoked by an 'unstable' set of relationships at home and in their communities. While many chose this form of self exile, others felt they did not have any choice but to come to the Shrine. Moreover, for a fraction of these attendees, the decision to come was out of their hands and they were taken to the Shrine against their will.

The stay at the Shrine could be seen as entering into a liminal or ambiguous state. The Shrine itself represented a space between or quite apart from their usual environment. The length of actual stay was unpredictable and a few stayed for many years. For some it appeared that the journey did end with a return to old relationships but "under new conditions" (Gesler, 1996 p. 96), but for a significant number it began or was part of a lifetime, of intermittent visits to the Shrine. Many others remained at the Shrine for a number of years with sometimes little prospect of returning home.

The visit to the Shrine although having similarities to a pilgrimage had other significant differences and outcomes. For those attendees returning to 'old relationships' some soon discovered that the relationships remained unchanged and either returned to the Shrine or visited other shrines. Sometimes the attendee themselves changed through the development of a new identity and found on returning home that there was an air of mysticism now surrounding

them and they were largely 'left alone' by others. The relationships changed as a result of the changed identity.

The Shrine, as an area representing tradition and the healing power of the dead, provided a space offering opportunities for therapeutic encounters (Conradson, 2005) to take place. Possession can be understood as a socially constructed vehicle allowing transformation in an individual to take place. The Shrine, although a place of contradiction and ambiguity, provided a boundaried space in which change occurred and attendees achieved varying levels of success with reintegration into society.

Although there was a great uniformity of belief concerning the Shrine and the healing process taking place there, a largely uncontested reality (Gesler, 1996), attendees at the Shrine did not all perceive or use the experience in the same way. They came from different home situations and embraced or enjoyed the everyday life of Shrine to different degrees.

INDIVIDUAL PERSPECTIVES ON HEALING

The definition and experience of healing requires the perspective of those experiencing it. Often in medical sciences, healing is proven or negated based on statistical measurement or through an individual's reintegration to 'normal' society. Those who do not meet these criteria are seen as either 'not healed' or 'treatment resistant'. In this study the attendees' perceptions of healing and the healing process were evident. Although not evidence based, they were whole heartedly believed.

Among the attendees there appeared to be four main groups of people who used the Shrine and the sacred space in different ways:

Shafayaab (healed)

Visitors to the Shrine who had undergone treatment and been completely and miraculously healed were referred to by other attendees as 'shafayaab' or the healed. These were perhaps examples of those successfully transformed by the experience. Although they were not present at the Shrine they were 'known' to be living happily in the community and served as an example and role model for attendees undergoing treatment at the Shrine. The miraculous stories of the 'shafayaab' were regularly shared between attendees. The 'shafayaab' were symbols of hope and represented the miracle.

Umeedwaar (Regular petitioner)

For some attendees, a re-negotiation of roles and identity did take place within the family. Changes in behaviour and attitude were made by both parties and these assisted in the attendees' reintegration into society. A recovered identity was perhaps more likely to be developed if the family was more flexible and able to negotiate roles and rules. After leaving the Shrine, the attendee and sometimes the whole family made brief visits every few months to experience *hazri* or to offer thanks in the form of donations and other offerings to the Saint. This group of regular petitioners were known as 'umeedwar'.

Rogi (sufferer in receipt of long term treatment)

Another group of attendees were called 'rogi', these individuals were seen as sufferers in receipt of long term treatment from the Saint. They managed their lives and relationships by having regular contact with and paying intermittent visits to shrines for reaffirmation of their beliefs and identity. This was a reminder to all that the change in or apparent healing of the 'rogi' was not permanent and that a relapse could occur. A persisting acknowledgement of the problem was required and an identity of 'I am possessed and therefore special' developed. It could have been that with each visit a therapeutic encounter took

place enabling a level of change in both attendee and family to take place. Over time, each encounter contributed to overall transformation.

Rihaaishee (permanent residents)

Some attendees had been living at the Shrine for more than a decade and were described by others as 'rihaaishee' or permanent residents. Rihaaishee described feeling completely healed and satisfied with their life and either chose to not go back to 'normal life', or they had no place to go. They found a sense of purpose and adjusted their lives to fit with the rhythm of everyday life at the Shrine. The life at the Shrine made the rihaaishee feel needed, respected, and valued as they had a clear purpose in their life. Possibly, in their former community, they would have been considered odd or a burden and perceived negatively. Living at the Shrine was clearly a way for some to control symptoms, a point raised by Halliburton (2003) and discussed earlier.

From a psychiatric point of view, it is possible that in Pakistan, these attendees would be labelled as institutionalised, stuck, or chronically ill. However, from the individual attendee's perspective, an informed choice had been made. It could be the inability of the person to adjust in society that was the issue, equally it could be society's inability to tolerate and embrace people who are 'different'. The attendees, who mostly came from a social context of low literacy, poverty, inequality, patriarchal rules, and oppression, expressed their distress in what is medically understood to be symptoms of mental illness. However, these symptoms also arose from extreme or dysfunctional families, rigid cultural rules and attitudes, and an intolerance of many forms of deviance or difference. The stressors drained individuals of their internal resources pushing them into a world of distress, isolation, and exile.

However, rihaaishee made up only a very small proportion of those visiting or using the Shrine for healing. As discussed above, for the majority of those seeking healing at the Shrine, a return home and reintegration into the

community, with a renewed identity always remained a possibility and for most was desired.

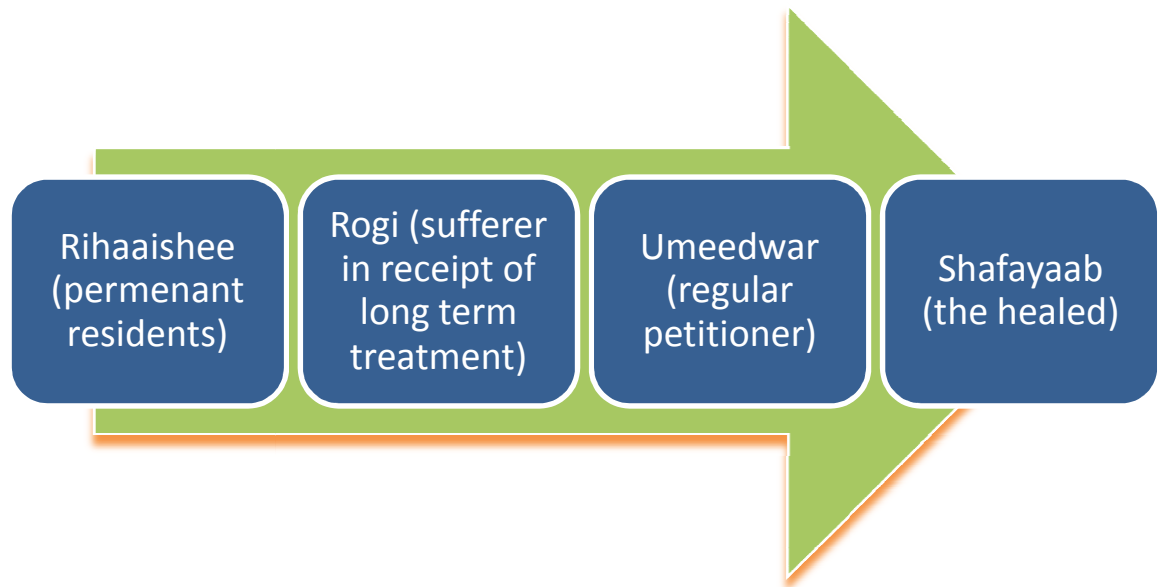


Figure 4: Four groups of visitors to the Shrine.

It was possible for attendees to use and experience the Shrine quite differently. The miracle cure was reported to have occurred from some whereas others used the Shrine intermittently or on a more regular and long term basis. For a few, the visit to the Shrine became permanent. It is also interesting to observe how aspects of the Shrine and the healing process were integrated into the life of attendees in the community.

THE SHRINE AS AN ‘EXTRAORDINARY’ LANDSCAPE AND RELATIONSHIP WITH THE ‘EVERYDAY’ LANDSCAPE

The therapeutic landscape literature focuses on research conducted either in what are termed ‘extraordinary’ landscapes such as shrines, spas and hospitals (Williams, 1998 ; Milligan et al., 2004 ; Gesler, 2005 ; Watson et al., 2007 ; English et al., 2008) or in an ‘everyday’ landscape (Wakefield and McMullan, 2005), examining the effects of day to day living environments. ‘Extraordinary’ landscapes can help people through even brief contact with the place and the

emotional support that they receive (English, 2008). The Shrine in the current study, like Lourdes, is an 'extraordinary' landscape.

However, visitors or participants in therapeutic landscapes are not "passive players...Instead of absolute positions, individuals often occupy a preferred evolving middle ground between isolation and integration between states of dependency and ones of independence" (Pinfold, 2001, P. 210). It is noted that in the current study there were attendees, particularly the 'rihaaishee' or permanent residents, for whom the 'extraordinary' landscape of the Shrine became their everyday environment. Their interaction with the landscape was neither brief nor fleeting and they chose to make the Shrine their permanent home. The 'extraordinary' landscape thus became the 'everyday' landscape. The benefits of the 'extraordinary' therapeutic landscape were completely incorporated into the day to day living experience of the 'rihaaishee' and in this way they maintained a level and sense of well-being (Halliburton, 2004).

Other attendees, such as the 'rogi' or long-term sufferer, tried to take a part of the 'extraordinary' landscape with them when they left the Shrine and attempted to incorporate the therapeutic landscape of the Shrine into their day-to-day lives at home. This was exemplified by those who dedicated a room or an area in their houses as '*Astaana*' which were effectively proxy shrines. In the area designated as the '*Astaana*' they paid their respects and resumed interactions and communications with the Saint. They experienced *hazri*, begged for mercy and healing and maintained the healing rituals in their home lives far from the actual extraordinary landscape of the Shrine. As well as bringing the 'extraordinary' into the 'everyday' this small proxy shrine also served to remind them and their families and communities of their new and altered identities, validated by the Saint.

Those visitors and attendees who took home with them massage oil; flower petals and holy water could also be viewed as attempting to take the

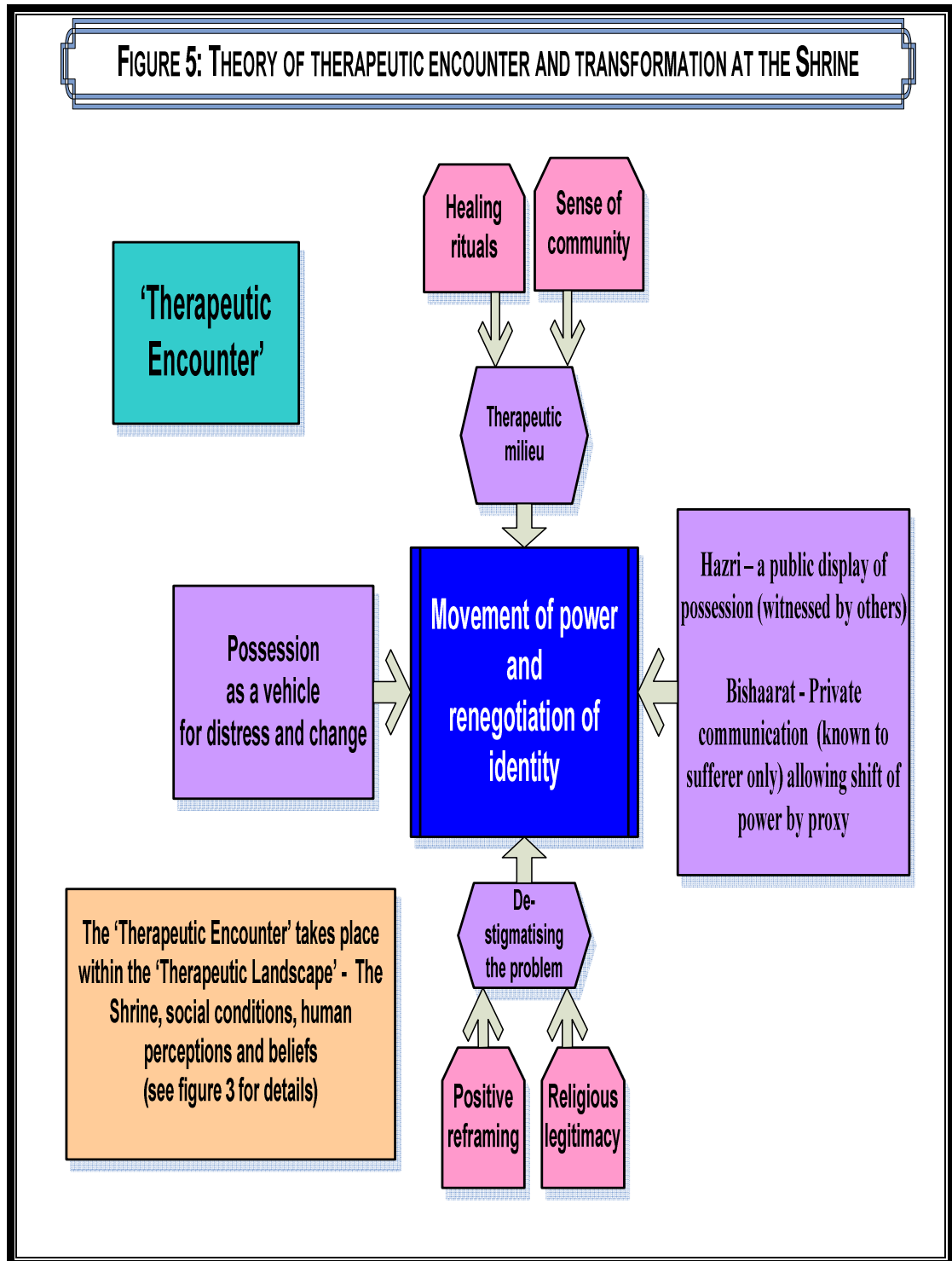
‘extraordinary’ into the ‘everyday landscape’. This notion of changing landscapes and attempts by ‘players’ to integrate the ‘extraordinary’ and the ‘everyday’ is not something that has received attention in the therapeutic landscape literature and is worthy of further exploration.

THEORY OF THERAPEUTIC ENCOUNTER AND TRANSFORMATION

Figure 5 attempts to explain the theory of ‘Therapeutic Encounter’ that takes place at the Shrine as a result of the movement and changes in where power is located within families and between individuals. The largely destigmatising environment, positive reframing of symptoms and problems and the renegotiation of identity within the therapeutic landscape of the Shrine essentially transforms the individual and makes the experience therapeutic. Possession acts as a vehicle for a subtle change in the family dynamics. It both guides the family decision-makers towards choosing the Shrine as a healing venue and frames the problem once they are there. The *bishaarat* represents the private communication taking place between the attendee and the ‘therapist’ (Saint). The *hazri* acts as a public display of the power of the possession and therefore relieves the attendee from responsibility for their actions and also demonstrates openly the treatment in action. The *hazri* also brings with it increasing respect and status for the sufferer. This ultimately allows a movement of power in which family members are complicit but do not openly acknowledge.

Despite the obvious contradictions and ambiguities, the Shrine with its perceived religious legitimacy, provides a place for attendees where having been removed from a stressful home environment and situation, they are given a positive identity. They share a language of distress with other attendees and develop a social network providing a platform for self-help and self healing. The Shrine, with its community of sufferers, routine of daily activities, its healing rituals and religion-focussed environment, contributes to the creation of a landscape which when combined with the prevailing social order and conditions

and the perceptions of attendees, becomes therapeutic and therefore a health care system in itself.



CONCLUSION

In conclusion, patriarchy and the prevailing social structure in Pakistan combined with attendees' beliefs and understanding of religion and the supernatural to orient them towards healing at the Shrine. Perceived failures of or dissatisfaction with allopathic treatment, as well as poverty and differing explanatory models of sickness served to limit choice of healing venue and made treatment at the Shrine seem more attractive. The Shrine offered the possibility of a miracle and this was constantly reinforced by the narratives of other attendees. Interestingly some attendees made the 'extraordinary' landscape into the 'everyday' by living permanently at the Shrine whilst others tried to recreate their lived experience of the Shrine at home.

It is not suggested that all who come to the Shrine will necessarily experience it as an 'authentic' therapeutic landscape as it can clearly be perceived as either 'authentic' or 'unauthentic'. However, I have tried to capture and interpret the voices of the participants' and their own evaluations of their healing experiences, whilst at the same time searching for a deeper meaning and understanding of the experience. For some, it was clear that a therapeutic encounter and transformation took place within the therapeutic landscape of the Shrine.

CHAPTER 7: CONCLUSION

INTRODUCTION

This final chapter considers what appear to be the main limitations of the study and then goes on to make a series of recommendations arising from the findings of the study and concludes by identifying a number of areas that would benefit from further investigation.

LIMITATIONS OF THE STUDY

A number of possible limitations to the study have been identified and outlined below:

- ❖ It could be a criticism of the study that definitions of what was considered a positive or ‘therapeutic’ outcome of the experience, by the participants, was subjective and there was no objective measuring of changes in mental or physical health over time. However, this research was intended to be a snapshot and what was considered important was the insider’s own view of their experience. Illness is a social process and it was the illness that was being ‘treated’ at the Shrine rather than a disease as such. Many people experienced improvements in physical, emotional, and social aspects of their well-being and these elements can only really be measured subjectively. The current study did not, from the outset, aim to measure the efficacy of healing rather it aimed to explore the experience of healing. Therefore no claims are made about the efficacy of healing either on its own or in comparison with other treatment modalities.
- ❖ Most participants were repeat visitors or long-stay residents at the Shrine, therefore this group had clearly chosen to be there and had found a ‘fit’ with this type of healing. They could therefore have found the experience more

positive than most, especially when compared to a wider cross-section of the community including those who visited the Shrine and found it an unsatisfactory experience. This may have led to a more narrow or singular picture of the Shrine being obtained. However, to some extent the participant observation allowed greater access to a broader population of visitors to the Shrine, some of whom came only for an evening or a day. These included those who had invested less, in terms of time and resources, in the healing experience and those who felt they had recovered and only returned for continued blessings from the Saint.

- ❖ The participants may have been those who had had particularly negative experiences with allopathic medicine. Those who had more positive experiences may not have felt the need to come to the Shrine in the first place. However, there were also aspects of allopathic medicine that clearly did act as a disincentive to its long-term use such as cost and affordability and access, and the literature consistently questions the competency of clinicians in the field of mental health in Pakistan.
- ❖ Women were over-represented in the sample (19 of 26 participants). This may have led to the findings being skewed towards the issues and experiences of women in that particular socio-cultural environment and the explanation and theory generated affected by this. The results may not be generalisable to the overall group of men coming to the Shrine. There is no data available showing the gender breakdown of all visitors to the Shrine. However, findings from other studies carried out at faith healers, shrines and temples show an over-representation of women generally using these health resources. Therefore, the presence of so many women in this study is not wholly unexpected. My own gender also affected who I was able to approach for an interview and also who felt comfortable in being interviewed by a woman. Male participants may well have felt restricted in what they

shared with me because of the gender difference and socio-cultural rules governing communication between males and females.

- ❖ Being an 'outsider' caused a lot of resentment among some Shrine attendees and the role of researcher was treated with scepticism. Questioning of the sacred was considered inappropriate by some. There may have been a desire to present a positive image to an 'outsider' and to gloss over the more negative aspects or experiences. It was difficult to overcome this except by building trust, being respectful and not challenging beliefs that seemed alien or bizarre to me. I made great efforts to fit into the culture of the Shrine through the way I dressed and behaved. In addition, participant observation was critical in the triangulation of the data.
- ❖ I came to the Shrine with my own set of values and beliefs about religion, mental ill-health and its causes, and gender relations. I was trained according to a western psychiatric model. In order to counteract any potential bias I constantly reflected on what was my own thinking about the experiences of attendees at the Shrine and what were their own perceptions. By being aware of my own beliefs and values during the data analysis and focussing on the data, I tried to remain as objective as possible. I also used other methods for data verification, as previously described, such as sending the transcripts to my supervisors for external opinion and sharing findings and themes with a group of attendees.
- ❖ There were 26 formal participants and the research took place in a single shrine over a three month period in the height of summer. This may have affected the type of data collected and accounted partly for the number of children present (it was the school holiday period). However, in order to widen the perspectives captured I used participant observation and informal interviews with visitors. The formal interview process continued until it appeared that the data was saturated; continuing to conduct interviews with

more attendees would have been unlikely to add anything further. The findings explain the experiences of those present at that particular shrine at that particular time and cannot be generalised.

There are clearly a number of limitations to this study but attempts have been made to mitigate these where possible and no claims are to being made as to the generalisation of the findings beyond the parameters of the research study.

RECOMMENDATIONS

Following consideration of the findings from the current study I make a number of recommendations:

- ❖ Health professionals need to recognise that distress can be expressed in terms of the supernatural. Looking at this expression through a medical lens may lead to inaccurate diagnoses and consequently treatment and compound the distress experienced. Possession itself should not simply be viewed as a psychiatric symptom or diagnostic category in its own right.
- ❖ In disadvantaged groups, such as women in patriarchal societies, it is important to focus not only on symptoms but to take into account the social and cultural context from which these symptoms arise. Finding a, possibly creative, solution that ‘fits’ with the beliefs and context of the patient will maximise chances of success. It is a mistake to assume that biomedical interventions are universally appropriate.
- ❖ Possession may be less stigmatising for individuals than a label of mental illness. It is important that individuals are allowed to ‘name’ their own problem rather than have a psychiatric diagnosis imposed that means little if nothing to them and may cause further confusion, mistrust and a discontinuation of treatment.

- ❖ Those health professionals practising in the developing world but trained according to a western psychiatric model must attempt to step back and reflect upon their own practice and how it 'fits' with the perspectives of the local population. The differences in perception and understanding between practitioner and patient may drive the individual to seek inappropriate help and compromise their safety. There is frequently mistrust between the two (practitioner and patient), and a scepticism about the beliefs of the other which undermines the possibility of achieving a therapeutic interaction or intervention. It is incumbent upon the practitioner to move to understand or appreciate the position of the 'other' however 'unattractive' or threatening this may appear.
- ❖ Health professionals must recognise the importance of alternative approaches to healing and explanations of problems (disease, illness and sickness) if they are to be able to deliver culturally competent care. Living in a multi-cultural society such as the UK, it is important to try to understand the 'emic' perspective and for that Kleinman's Explanatory Model provides a useful tool to gain socio-cultural understanding of the patient's world and find best 'fit' in terms of care and treatment.
- ❖ Psychiatry is a very male dominated profession in Pakistan. It is important that medical education and training addresses social and gender issues and their relationship with mental health if women in Pakistan are to receive the health services or, possibly more appropriately, the social services that they need.
- ❖ The safety of visitors to shrines, particularly women and children, is an important issue. Already vulnerable individuals were clearly at risk of harm and abuse. The Ministry of Religious Affairs in Pakistan needs to take safeguarding issues more seriously and make further attempts to protect attendees, whether short or long-term visitors, from harm.

AREAS FOR FURTHER INVESTIGATION

There are a number of topics that it would be beneficial to investigate further. These include the following:

- ❖ This is one of only a very few studies carried out in shrines and the only one that has tried to understand the ‘emic’ perspectives of those seeking healing. There needs to be further research in this area in order to build a body of knowledge concerning the therapeutic processes that are taking place at shrines. The micro-processes that contribute to healing for attendees should be examined further to ascertain their relevance to medical psychiatric care as practised in Pakistan.
- ❖ All the studies in the literature exploring patients’ experiences of faith healing have focussed on faith healers only and have ignored faith healing venues. The current research has shown that faith healing venues are widely used for varying periods of time (sometimes for years) and need to be taken into account. Faith healing as a concept is far broader than just consultations with faith healers and this should be recognised if an accurate overall picture is to be gained.
- ❖ The visiting of shrines and its relationship with health and healing should be further investigated from the perspective of ‘therapeutic landscape’ and ‘therapeutic encounter’. The relationship between health and place in this context is under-researched. There has not been a single study of this kind in Pakistan other than the current study.
- ❖ The shift of power generated and enacted through *hazri* and *bishaarat* is a very interesting finding in this study. There is scope to examine this powerful process in more detail from a Systems Theory perspective and this would undoubtedly be valuable.

- ❖ The way in which some attendees made the ‘extraordinary’ landscape their ‘everyday’ landscape by living at the Shrine permanently and others built small shrines in their homes in order to incorporate the ‘extraordinary’ landscape into their ‘everyday’ landscape is an issue that remains unexplored in the therapeutic landscape literature and is worthy of further research in itself.

A number of recommendations have emerged from the study. Some of these are aimed at reducing the ‘distance’ between the health professional and the one seeking healing, improving the therapeutic relationship, and increasing the chances that culturally competent treatment and care will be provided. Further, a number of areas requiring more investigation are identified, including more research to be carried out in shrines from the point of view of those seeking healing and exploring the relationship between health and place.

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APPENDICES

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APPENDIX 1: GLOSSARY

- *Astaana* - Proxy shrine of the Saint in an allocated room/area of the home – the area is kept pure at all times and treated as a shrine. People visit and pay their respects and often experience *hazri* as well
- *Amal* - To mutter a spell
- *Baaba* - A term generally used for an older and respectable man. Sometimes used to refer to one's father. In the current context it is used for the Saint - Hazrat Abdullah Shah Asahabi
- *Baaba Ramzani* – A saint whose grave is located at the right hand corner of the Shrine compound. Disruptive, violent or difficult to control attendees were tied to the metal grill (surrounding the grave), in the belief that this would control the behaviour of the afflicted.
- *Bishaarat* - a special and private communication or conveyance of message between the Saint and the attendee.
- *Durgah* - The most sacred place in the shrine where the grave of the Saint is placed. It is a small and congested room, brightly coloured and perfumed. The grave is covered with several colourful sheets of cloth [green and red with tinsel] and flowers. The room is also heavily perfumed with burning incense sticks. There are big metallic trunks installed in the corners inviting donations from visitors.
- *Fatiha* - A visit to a shrine by followers to offer prayers and respect for the dead saint, so that their lives can be blessed.
- *Ghabrahat* - has been described as: fear, nervousness, apprehensiveness, anguish etc. It also includes physical symptoms like perspiration, loose-motions, trembling, and sinking heart (Chimthanawala, 1993)
- *Goosul Mubarak* - the ritual bathing of the grave of the Saint which occurs once a year; drinking the water used for bathing the grave is considered healing
- *Hazri* - A process in which there is an interaction between the Saint and the evil spirits
- *Izzat* - Reflected shame and honour (the shame and honour that can be brought to others by one's own behaviour)

- *Jaali* - Metal grill covering the windows fixed in the *durgah*. People from outside the *durgah* would touch the *jaali* to see the grave and to communicate with the spirit of the Saint.
- *Jinn* - (singular or plural), a spirit; or a demon, can be both enemy or a friend or protector to the human being
- *Khadima* - Female servant – in the context of the Shrine, it was used for the female caretaker
- *Lunghar* - The food distributed at the Shrine – it could be sweet or a meal served in the alms house
- *Magic reading* - Belief that magic spell is cast through a potion of food on which verses were read to make it harmful
- *Mai Makli* - was a small shrine for a female Saint, located locally and attended by some followers.
- *Makki Shah* – Another well attended shrine in a different part of the province
- *Nochandi* - The night of the first lunar Thursday each month (begins Thursday evening and ends early morning on Friday and is considered a significant decision day at the Shrine)
- *Puja* - religious ritual performed by Hindus on a variety of occasions to pray, show respect to God and seek healing
- *Qur'an*: is the religious text of Islam. Muslims believe the Qur'an to be the book of divine guidance and direction for all human beings.
- *Saya* - being possessed by an evil spirit
- *Sharia* - Sharia is the body of Islamic religious law. It is the legal framework within which the public and private aspects of life are regulated for those living in that legal system. *Sharia* deals with many aspects of day-to-day life, including politics, economics, banking, business, family, sexuality, hygiene, and social issues.
- *Urs* - The birthday of the late Saint

APPENDIX 2 – PARTICIPANT INFORMATION SHEET AND CONSENT FORM

MIDDLESEX UNIVERSITY
SCHOOL OF HEALTH AND SOCIALSCIENCES

HEALTH STUDIES ETHICS SUB-COMMITTEE

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Research Title: Attendees’ perceptions and experiences of help seeking at a Muslim shrine of Hazrat Abdullah Shah Asahabi and its impact on mental health’

Invitation Paragraph:

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

Traditional beliefs and religion is an important part of life for people in Islamic cultures. It is widely accepted that individuals and families seek religious healing to improve their mental, physical, emotional, and spiritual health (Khowaja, 2001; Saeed et al, 2000; Mubbashar & Saeed, 2001). Faith rituals such as prayer, attending a place of worship or carrying out religious practices can give structure and meaning to life and therefore make significant impact on one’s mental health (Flannelly & Inouye, 2002).

Over the years, a large number of people, from all over Pakistan, visit and reside in the shrine of Hazrat Abdullah Shah Asahabi and seek healing for physical, mental, social and spiritual well being. The reasons that bring people to this shrine and how it helps in promoting well being are however not clearly understood. The study therefore aims to

- Investigate the attendees’ reasons for attending a Muslim shrine in Pakistan
- Explore individuals’ perceptions and experiences regarding the role, a Muslim shrine plays in helping with mental distress
- Develop a theory about the role of faith in regards to mental healing among attenders of a Muslim shrine in Pakistan

- Avail this theory to health professionals as a complementary approach to inform their practice.

Why have I been chosen?

As an attendee of this shrine, who has been residing here for at least three (3) days, I am approaching you to seek your willingness to participate in the study. I will approach at least thirty (30) other attendees for their contribution in this study. The information you provide will help me in understanding the reasons that bring people to a shrine and how 'being at a shrine' impacts on their mental well being.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you in anyway.

What will happen to me if I take part?

If you decide to take part in the study, I will request you to give me a time slot of a minimum of one hour. During that hour, I will collect information to answer the above mentioned research questions by talking to you about your views and experiences. This interview can last for about 45-60 minutes and will be conducted in a separate room or private area. As it may be difficult for me to take notes during the interview, I would like to tape record the interview with your permission so that after the interview, I can accurately compile all the information you provided to me during the interview.

If it is convenient for you, you can give me your postal address and I can send you in writing, all the major points of your interview. You can suggest additions, deletion or modification to reflect what you meant.

What are the possible disadvantages and risks of taking part?

There are no disadvantages or risk in taking part. As stated before, you will have the right not to answer any specific question or withdraw from the study at any time.

What are the possible benefits of taking part?

There is no particular benefit to you from this research in regards to your physical or mental health. However, information you provide will help me in understanding what brings people to Muslim shrines and what role these Muslim shrines play in regards to healing.

Will my taking part in the study be kept confidential?

All information that you provide about you and your experience during the interview will be kept strictly confidential. Any information about you which I use will have your name removed so that you cannot be recognised from it.

What will happen to the results of the research study?

The results from the study will be analysed and compiled into a thesis (university report) during the next two years. Locally, I will publish a summary of my findings in a form of a newspaper article. Be assured that none of those who participate in the study will be identified in any report/publication.

Who has reviewed the study?

The proposal for this study has been reviewed and approved by the Health Studies Ethics Sub-Committee of Middlesex University, London.

Contact for further information:

If you have any concerns or questions, you can contact me directly

Researcher: Farida Pirani
C/o AmirAli Noorani
Aga Khan University School of Nursing
PO box 3500, Stadium Road
Karachi 74800, Pakistan
Telephone: 021-48595439 [8:30 am to 5:30 pm]

Thank you very much for considering taking part in this study

If you decide to take part in the study, you will be given a copy of the information sheet and a signed consent form to keep.

Patient information sheet and consent Version 1- December 22, 2004

(Headed paper)

Centre Number:

Study Number:

Patient Identification Number:

CONSENT FORM

Title of Project:

Attendees' perceptions and experiences of help seeking at a Muslim shrine of Hazrat Abdullah Shah Asahabi and its impact on mental health'

Name of Researcher: Farida Pirani

Please initial box

1. I confirm that I have read and understand the information sheet datedfor the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
3. I agree to take part in the above study.
4. I agree to have my interview audio-recorded

Name of Participant

Date

Signature

Name of Person taking consent
(If different from researcher)

Date

Signature

Researcher

Date

Signature

1 copy for participant; 1 copy for researcher;

APPENDIX 3: DEMOGRAPHIC DETAILS OF THE PARTICIPANTS

Research ID	Pseudonym	Age (approx)	Marital status	Education	Accompanied by	Length of stay	Category	Source of referral
RP-F-01	Tara	18	Single	Primary education	Mother and siblings	On and off for last 9 months	Repeat visitor	Family
RP-F-02	Farhana	25	Separated/ Divorced	Can read Qur'an	On her own	15 days	Moving from shrine to shrine	Through <i>bishaarat</i>
RP-F-03	Rana	26	Single	Primary education	Mother	On and off for last 6 years - currently many months	Repeat visitor	Through <i>bishaarat</i>
RP-F-04	Sada	55	Separated/ Divorced	Illiterate	On her own	2 weeks	Repeat visitor	Family
RP-F-05	Wari	48	Married	Illiterate	Husband and daughter	about 3 months	First time visitor	Faith Healer
RP-M-06	Moadit	35	Married	Can read basic text - no formal education	On his own	Currently for 3 years (has been visiting for the last 8 years)	Repeat visitor	Family
RP-F-07	Zara	45	Widow	12th Grade	On her own	3 months now, on and off for last 15 years	Repeat visitor	Self referral

RP-M-o8	Muhib	45	Single	10th Grade	On his own	12 years	Permanent resident of the Shrine	Self
RP-F-09	Subha	30	Married	12th Grade (commerce)	Husband and two young children	Currently for 3 months. Previous visits 12 years ago	Repeat visitor	Through <i>bishaarat</i>
RP-FC-10	Sabiha	Mother 55, Caring for son 24	Widow	Illiterate	Unwell daughter	2 weeks (son had been living unaccompanied for last 2 years)	Repeat visitor	From another shrine
RP-FC-11	Nagri	Mother – 80 caring for son - 40	Widow	Illiterate	On their own	3 years	Resident?	Through <i>bishaarat</i>
RP- F-12	Nasr	40	Married	Primary education	On her own	First time for healing - has accompanied her relatives in the past	First time visitor	Family
RP-FC-13 RP-F-13	Sabiha & Hira	Mother - 55, Daughter 18	Widow Single	Illiterate 10 th grade	Unwell son	2 weeks	Repeat visitor	From another shrine
RP-F-14	Fehmida	25	Single	BA degree	On her own	On and off for last 7 years - currently for 2 weeks	Repeat visitor	Father's friend

RP-FC-15 RP-F-15	Kauser (mother) and Kayla (daughter)	Mother - 45, Daughter 20	Mother - Married, Daughter - single	Mother - 10th grade, Daughter 12th Grade	On their own	7 days	First time visitor	Relative
RP-M-16	Hamad	56	Married	10th Grade	On his own	'A long time' (many years)	Resident of the Shrine	Self
RP-F-17	Akeela	35	Married	BA degree	On her own	4 weeks	Repeat visitor	Faith Healer
RP-F-18	Moomal	45	Married	Illiterate	On her own	On and off for the last 5-6 years, currently for 1 week	Repeat visitor	Faith Healer
RP-M-19	Rafique	45	Married	Primary education	With his sister	4 days	Repeat visitor	Family
RP-F-20	Seema	40	Married	Primary education	With other attendees from another Shrine	1 week	Repeat visitor	Hakeem
RP-FC-21	Sharifa and Ana	Mother 35, daughter 8 years	Married	Illiterate	On their own	3 days	Repeat visitor to different shrines	Through <i>bishaarat</i>
RP-FC-22	Shaheena (Mother) caring for Saima	Mother - 50 years, daughter 25 years	Mother - Married, Daughter - single	Mother - BA degree, Daughter 12th Grade	On their own	A few weeks	Repeat visitor	Faith Healer
RP-F-23	Sareena	35	Married	Illiterate	Young son (10 years old)	1 week	First time visitor	Doctor?

RP-MC-24	Fazal (father) caring for Sabeena	Father - 45 years, Daughter 20 years	Divorced	12th Grade	On their own	6-8 weeks, had spent about 3 months at the Shrine earlier in the year	Repeat visitor	Self referral
RP-F-25	Rizwana	70	Married	Illiterate	On her own	3 months now, on and off for last 21 years	repeat visitor/ residing at different shrines	Faith Healer
RP-MCT-26	Manzoor (Shrine caretaker)	55	Married	10th Grade	N/A	Employed at the Shrine for last 20 years	Shrine employee	N/A

APPENDIX 4: GUIDE QUESTIONS FOR SEMI-STRUCTURED INTERVIEW

- a. What brought you here?
 - a. Name of the problem that brought individual to the shrine
 - b. When and how did it start?
 - c. What caused the problem
 - d. nature and description of the problem - how severe is the problem
 - e. Perception about factors that triggered the onset of problem [timing part]
 - f. *Is supernatural possession cause or a symptom?*
 - g. *What makes you (or your family member) vulnerable to this problem?*
- b. Tell me what impact does this problem have on your life and lives of those around you?
 - a. how has this problem affected you and those around you in past and in present ?
 - b. Impact of problem on individual's life – in past and in present [physically, emotionally, spiritually, socially] give examples
 - c. Impact of problem on others' [significant others, community] give examples
 - d. *How do you think your problem is perceived by others outside the shrine and those in the shrine?*
 - e. *How does this perception affect you and your family members?*
- c. How did you decide to come to the shrine?
 - a. What path has an individual taken before coming to shrine – friends, local health care, hakeem, faith healers, talismans
 - b. Source of information for the shrine – family, previous attendees, sign from supernatural forces
 - c. When did you hear about the shrine [time it required before decision of seeking help from the shrine was taken]
 - d. Arrival at shrine
 - e. Decision making process – who and what influenced
 - f. other choices/options individual had other than other than residing at shrine?
 - g. *What might have been the situation if you had continued living at home?*
- d. Describe your daily routine while living at the shrine
 - a. Routine – from waking up in the morning to going to sleep
 - b. Meaning and significance of rituals performed at various timings

- c. How does it differ from routine at home?
 - d. Most likable/useful activities or rituals while living at the shrine
 - e. Least likable/useful activities or rituals while living at the shrine
 - f. *What is the importance of being 'at the shrine'?*
 - g. *Can the ritual be performed at home? Is there a difference in its effectiveness?*
- e. What are your perceptions about the role of shrine in regards to problem that brought you here?
 - a. How has it helped?
 - b. How will it help?
 - c. most important results one hopes to achieve
 - d. most useful aspect of being in the shrine
 - e. least useful aspect of being in the shrine
 - f. What can relieve the problem completely
 - g. Can the problem be relieved completely?
 - h. *Can the problem be eliminated from the root?*
- f. How has living in the shrine affected you?
 - a. Physically,
 - b. emotionally,
 - c. socially,
 - d. spiritually
 - e. *your relationship with others in your family*
- g. How long do you think you will be staying at the shrine?
 - a. Time for going home
 - b. Who decides
 - c. Indications for going home - changes in health status or..
 - d. Contribution from other factors – safety, money, etc.
 - e. *How would you know it is time to go home?*
 - f. *What are the consequences of leaving early?*
 - g. *Who can help you interpret what the Saint is communicating to you?*
- h. What do you aim to do after you leave shrine?
 - a. Next destination – home or help seeking
 - b. Any other resources – what help will those resources provide?
 - c. *How long do you think improvement would last for?*
 - d. *What are your and your family's expectations concerning your recovery? What is the follow up plan?*

APPENDIX 5: ETHICS COMMITTEE APPROVAL LETTER



**Middlesex
University**

School of
Health and Social Sciences
The Archway Campus
Furnival Building
10 Highgate Hill
London N19 5LW

20th January 2005

Dear **Farida Pirani**

Re: *'Attendees' perceptions and experiences of help seeking at a Muslim shrine of Hazrat Abdullah Shah Asahabi and its impact on mental health'.*

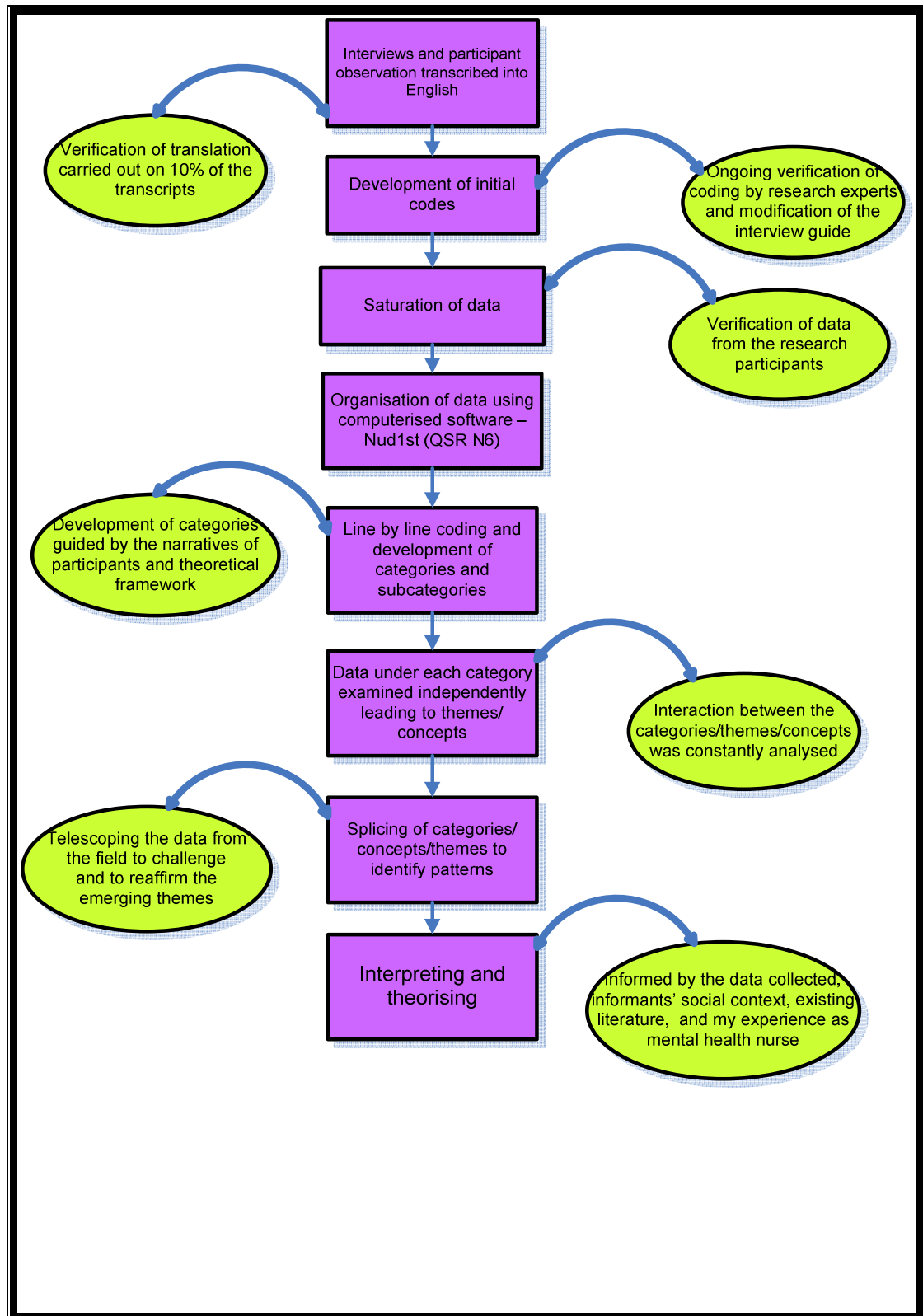
Thank you for the response which adequately answers the ethics committee's queries. On behalf of the committee, I am pleased to give your project its final approval. Please note that the committee must be informed if any changes in the protocol need to be made at any stage.

I wish you all the very best with your project. The committee will be delighted to receive a copy of the final report.

Yours sincerely

Professor (I) Rena Papadopoulos
Chair of Ethics Sub-committee (Health Studies)

APPENDIX 6: PROCESS FOR DATA ANALYSIS



APPENDIX 7: ALLOPATHIC MEDICINE AND THE SHRINE - AN ALTERNATIVE HEALTH CARE SYSTEM IN PARALLEL

Factors/ Variables	Allopathic care in Pakistan	Shrine as an alternative health care system
Place	Hospitals, clinics, located in towns and cities with demarcated boundaries	Shrines, located in the cities or on the outskirts, as well defined geographical locations with concrete boundaries
Therapist/ healer	Psychiatrist, General doctor	The absent healer – the spirit of the Saint (represented by the holy grave). Religious leaders, and mystic healers with healing abilities, and learned through religious texts – not available at all shrines
Locus of control	Doctors, family members accompanying the ‘patient’. Family responsible for providing financial means and making decisions.	Saint in a virtual world. Enacted through the attendee. Family members in cases when the person is not willing to stay at the Shrine or is restrained and made to stay there against their will.
Causative explanation	Biomedical – emerging from western psychiatric concepts University education loosely governed by medical PMDC (Pakistan Medical and Dental College), governed by written texts	Based on an eclectic approach – derived from Sufi tradition, mystic and supernatural events, and stories presented in the Qur’an and <i>Hadith</i> , and other religious literature. Oral narratives particularly important in transmitting theories of causation
Consent	Voluntary/ involuntary	Mostly voluntary but some involuntary
Treatment or therapy orientation	Medications and nutrition supplements hospitalisation, ECT, mainly verifiable and evidence based.	Experiencing trance like state when direct ‘communication’ with the Saint is established, practising modest ways of living, engaging in prayers and religious activities, The treatment is based on implicit knowledge (of the healer) in the form of rituals etc. – not

		verifiable
Stigma	High level	Low to moderate levels
Therapeutic or side effects Pleasant or unpleasant effects	Control of agitation and overactive behaviour with medication Drowsiness, hot effects causing diarrhoea, changes in BP, weight etc. Long term use of medication – unpleasant and harmful, perceived complications ECT- perceived and experienced as harmful to brain, dangerous without anaesthesia	Being at the Shrine was perceived as psychologically, emotionally, and spiritually pleasant although physically uncomfortable most of the time. Rituals and activities at the Shrine were primarily perceived to be pleasant, although not necessarily therapeutic. Isolating from society, restrictions imposed on ways of living, <i>hazri</i> was considered a physically painful process.
Effects on family	Adjustments in the household to accommodate sick person	The sick person is accommodated in the Shrine environment – often a family member stays with the attendee, respite for all family members – necessitating changes in household arrangements
Financial resources	Self payment for private health care. Subsidised or free treatment at government hospitals	Free accommodation. Participation in all shrine rituals is free except occasional expenses of buying flowers for the grave or for distributing sweets as an offering. The attendee pays for own food and other utilities (e.g. use of bathroom etc.)
After-care	Follow-up visit to doctor, more medication	Continuation of visit to Shrine on a weekly, monthly and then yearly basis Support from community sharing similar beliefs, attendance at congregations at the Shrine (held at least each month).

APPENDIX 8: MAJOR THEME DISTRIBUTION FROM DATA ANALYSIS

Research ID	Physical problems	Emotional problems	Family misfortune	Magic and/or Possession	Bishaarat	Hazri	Exclusion/ and stigma	Domestic violence	Financial problems	Sought medical help	Having parallel	Peace at shrine	Discomfort at shrine	Involvement in rituals
RP-F-01	✓	✓		✓	✓	✓	✓		✓	✓			✓	✓
RP-F-02	✓			✓	✓	✓	✓	✓	✓			✓		✓
RP-F-03	✓	✓		✓	✓	✓	✓	✓? ²⁵	✓			✓	✓	✓
RP-F-04	✓	✓		✓	✓	✓			✓	✓		✓	✓	✓
RP-F-05	✓			✓	✓	✓				✓	✓	✓		✓
RP-F-09	✓	✓		✓	✓	✓		✓?		✓		✓		✓
RP- F-12	✓	✓		✓				✓		✓			✓	✓

²⁵ ? has been used when although there was domestic violence was not openly acknowledged but there were hints/suggestions that this was the issue with the participants.

RP-F-14	✓	✓		✓	✓		✓			✓		✓	✓	✓
RP-F-17	✓	✓	✓	✓	✓	✓	✓	✓?		✓		✓	✓	✓
RP-F-18	✓	✓		✓	✓	✓				✓	✓	✓		✓
RP-F-20	✓	✓		✓	✓	✓	✓			✓		✓		✓
RP-F-25	✓		✓	✓	✓		✓		✓			✓		✓
RP-F-23	✓	✓		✓		✓	✓	✓	✓	✓			✓	✓
RP-F-07	✓		✓	✓	✓		✓		✓	✓		✓		✓
RP-M-08	✓	✓		✓	✓	✓				✓		✓		✓
RP-M-06	✓	✓		✓	✓	✓	✓			✓		✓	✓	✓
RP-M-19	✓			✓	✓				✓	✓	✓	✓		✓
RP-M-16	✓			✓	✓	✓	✓		✓	✓		✓		✓
RP-FC-13 RP-F-13		✓		✓	✓	✓	✓	✓	✓			✓	✓	✓
RP-FC-15 RP-F-15	✓			✓	✓	✓	✓		✓	✓		✓		✓

RP-FC-10		✓		✓	✓	✓	✓		✓	✓		✓		✓
RP-FC-11		✓		✓	✓	✓	✓		✓	✓		✓	✓	✓
RP-FC-21	✓			✓	✓	✓	✓		✓	✓		✓		✓
RP-FC-22		✓	✓	✓	✓	✓	✓	✓				✓		✓
RP-MC-24		✓		✓	✓	✓			✓	✓		✓		✓
RP-MCT-26	✓	✓		✓		✓		✓	✓	✓		✓	✓	✓

APPENDIX 9 – PUBLICATIONS AND PRESENTATIONS

Pirani, Farida M., Papadopoulos, (I)Rena, Foster, John and Leavey, Gerard (2007) "I will accept whatever is meant for us. I wait for that – day and night": The search for healing at a Muslim shrine in *Pakistan*', *Mental Health, Religion & Culture*, 11:4, 375 - 386

Pirani, Farida & Papadopoulos, (I)Rena (2007) Researching the sacred: Reflections on the challenges and ethics of data collection. *Journal of Health, Social and Environmental Issues*, 8,1, Spring Issue, 19-25.

Pirani, F. Papadopoulos, R., Foster, J. and Leavey, G. '*Pathways to healing: Explanatory models of mental distress and help seeking among attendees at a Muslim shrine in Pakistan*'. Poster presentation at the Postgraduate Summer Research Conference held at the Middlesex University on 25 June 2005

Pirani, F. Papadopoulos, R., Leavey, G and Foster, J. '*Understanding and explaining mental distress: Narratives from attendees at a Muslim shrine in Pakistan*'. Paper presented at the Qualitative Research on Mental Health Conference held in Tampere Hall, Tampere, Finland, 29 June – 1 July 2006.

Pirani, F. Papadopoulos, R., Foster, J. and Leavey, G. *Pathways to healing: Explanatory models of mental distress and help seeking among attendees at a Muslim shrine in Pakistan*. Poster presentation at the Postgraduate Summer Research Conference held at the Middlesex University on 25 May 2007

Pirani, F. Papadopoulos, R., Foster, J. and Leavey, G. *Understanding and explaining distress: conceptions of mental health/ ill health from attendees at a Muslim shrine in Pakistan*. Paper presented at the XIXth World Congress of the World Association for Social Psychiatry - Changing world: Challenges for society and social psychiatry, held in Prague, Czech Republic from 21-24 October 2007.

APPENDIX 10: SOME PICTURES FROM THE SHRINE



PICTURE IV: THE CEMETARY AROUND THE SHRINE



PICTURE V: LONG WINDING PATH LEADING TO THE SHRINE



PICTURE VI: A SMALL CANTEEN IN THE SHRINE



PICTURE VII: A SMALL SHOP SELLING FLOWERS, SWEETS AND CLOTHES TO THE SHRINE VISITORS



PICTURE VIII: A YOUNG WOMAN CHAINED TO THE GRILL - TO CONTROL THE EVIL SPIRIT



PICTURE IX: WOMEN'S PRAYER AREA